

**TUTOR MOTIVATION AND RETENTION IN PUBLIC HEALTH TRAINING
INSTITUTIONS IN GHANA: AN EXPLORATION SEQUENTIAL MIXED
METHODS STUDY**

Christopher Baasongti Beyere

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DECLARATION

The manuscript is my original thesis conducted for the award of a Doctor of Philosophy degree.

This work has not been presented for a degree at any other University.

Signature

Date.....

Christopher Beyere Baasongti

Student I.D: 14008694

Supervised and approved by:

Name

Signature

Date

Prof. Alastair Ager

.....

.....

Dr. Karina Kielmann

.....

.....

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DEDICATION

"Surely goodness and mercy shall follow me all the days of my life, and I will dwell in the house of the Lord forever." *Psalm 23 v. 6*:

This work is dedicated to the following:

Casimir Beyere	-	Dad
Comfort Akanwee	-	Mom
Francisca Dun	-	Mom
Felix Dun	-	Uncle
Ernestina Awisi-Yeboah	-	Wife
Morecia Beyere Baasongti	-	Daughter
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Isabela Beyere	-	Sister
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Evans Danso	-	Comrade

LIST OF ABBREVIATIONS & ACRONYMS

RN	-	Registered Nurses
RM	-	Registered midwife
DC	-	Disease control
EH	-	Environmental health
HT	-	Health tutor
RP	-	Rural principal
UP	-	Urban principal
FGD	-	Focus group discussion
KII	-	Key informant interview
HRH	-	Human resources for health
PHC	-	Primary health care
CHW	-	Community Health Worker
MDG	-	Millennium development goals
SDG	-	Sustainable development goals
UNDP	-	United Nations Development Programme
GHS	-	Ghana Health Service
GoG	-	Government of Ghana
SPSS	-	Statistical Package for Social Sciences
EU	-	European Union
WHO	-	World Health Organization

DEFINITION OF KEY TERMS

Trotro means public transport using a van or bus

Rural/ Urban: The classification of localities into ‘urban’ and ‘rural’ was based on the size of the target population. In this study, all localities with 5,000 or more persons were classified as urban, while localities with less than 5,000 persons were classified as rural (GSS, 2012). The rural schools explicitly located in the northern parts of Ghana are Nalerigu, Gushiegu, Kpembu, Yendi, Zuarungu, Damongo, Bole, and Kintampo College of health. While the urban schools located in the southern part of Ghana specifically are Korle- Bu (five schools), and Komfo Anokye (two schools)

Field means a clinical site or hospital.

Human resources for health (HRH) is defined as the different kinds of clinical and non-clinical staff responsible for public and individual health intervention (Ojakaa, Olango & Jarvis, 2014).

Leadership: A relationship through which one person influences the behaviour or actions of other people towards a goal (Gwavuya, 2011).

Remuneration: The distinct type of financial rewards which include salary, direct benefits, and performance pay (Mtazu, 2009).

Staff retention: The ability of an organization to engage valuable staff for an extended period. It is a voluntary move by an organization to create an environment, which engages employees in the long term (Michael, 2008).

Supervision: This is the ability to get work done through other people so that organizational objectives are achieved (Okumbe, 2001).

ABSTRACT

Policymakers in the health sector continue to look for ways to improve the staffing of rural health facilities. However, only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectations of the society (WHO, 2016). Extensive research has been conducted on health worker motivation and retention in the clinical settings, but relatively little is known of the situation of staff in the Ministry of Health training institutions. Health-training institutions play a significant role in strengthening the health workforce of the country by training all the middle-level cadres of health professions like Nurses, midwives, and other affiliated health professionals (MoH, 2015). This thesis reports on a mixed-methods study of health tutors in some selected public health training schools in the northern part of the country, predominantly rural-based and some in the southern region, primarily urban-based. Focus group discussions engaged 100 health tutors from across rural and urban schools. Five in-depth interviews and five key informant interviews were conducted with past health tutors and principals, respectively. Focus group discussions and interviews informed the development of a structured questionnaire comprising closed and opened ended questions. The quantitative study used a representative sample of 329 health tutors. Non-parametric (Spearman ranked correlation, Pearson Chi-Square, and Wilcoxon-Mann Whitney) and parametric (t-test and ordered logistic regression) statistical tests were run. Findings suggest that most tutors actively compare their income, benefits, qualification to that of their colleagues in other schools, and with other general health workers in the clinical area and lecturers within the ministry of education. From the findings of the results, personal characteristics of the health tutors, such as his or her place of origin, rural or urban, gender, age, and family background, have a significant impact on their employment decisions. There was evidence from this research demonstrating that rural upbringing increases

the chances of rural practice. While rural and urban health tutors equated motivation with money, those working in urban settings ranked accommodation as a significant factor influencing employment choice. In conclusion, the study examined differences in health tutors' motivation and retention and some recommendations.

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CHAPTER 1

1.1 Introduction

Interest in this study dates back to 2002 when the researcher was a tutor at the Kintampo College of Science in a rural area in the Northern Region of Ghana. The researcher observed that due to the large class sizes and few tutors, health tutors spent a considerable amount of time researching, teaching, and marking scripts with little time left to spend with their families. The imbalance in the work-life of the tutors made some of them go for other training institutions where there were more tutors and less workload. The situation can partly be attributed to the absence of incentive policies and practices to motivate the tutors and retain them in rural areas. The World Health Organization (WHO) highlighted the importance of human resources by the 2016 report of the titled *Global strategy on human resources for health: Workforce 2030*. In that report, the World Health Organization indicated that the mere availability of health workers was not sufficient for the effective delivery of health. The availability of health workers must include their equitable distribution and accessibility to the entire population, the possession of health workers of required competency, appropriate motivation, and empowerment to deliver quality service that is appropriate and acceptable to the sociocultural expectations of the population (WHO, 2016). The World Health Organization proposed, among other strategies, attraction and retention policies, a manageable workload, continuing education, and professional development, family and lifestyle incentives, hardship allowances, housing and education allowances, adequate facilities and working tools, and equitable deployment of health workers to rural and underserved areas to improve performance and ensure equitable distribution of health workers (WHO, 2016).

This study will examine how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana. The study brings an understanding of how tutors in public health training institutions in rural and urban areas of Ghana are being

motivated, adequately resourced, and equitably deployed, particularly in rural and underserved areas in Ghana. The study would help public health policymakers equitably distribute, inspire, and incentivize tutors of public health training institutions.

This chapter will provide the background and contextualization of the issue for this study. After the contextualization, a statement of the research problem, the purpose of the study, the central research question, and the specific research questions. The sections that follow will include an overview of the theoretical frameworks and methodology to guide the study. The chapter will also address the delimitations and limitations of the study, definition of terms used throughout the manuscript, followed by the significance of the study, and an overview of the organizational structure of the research and a summary of the main ideas.

1.2 Background and Contextualization of the Issue

Trained, skilled, and motivated health workers are essential to delivering high-quality healthcare (WHO, 2006). Policymakers in the health sector are always looking for ways to improve the staffing of rural health facilities by attracting health workers to rural areas and retaining them. However, low- and middle-income countries often find it harder to achieve a balanced distribution of their health workforce. The reasons behind this are that these countries have severe shortages of health personnel and large rural populations and presumably a lack of funds or taxable base or low GDP from which to invest in public healthcare (WHO, 2010). The attraction and retention of health workers in remote and rural areas are subject to two interrelated aspects: the factors that determine whether or not health workers will stay in rural health facilities, and the policies and strategies adopted by policymakers in response to these factors (Lehmann et al., 2008). The literature describes many factors that explain why health workers decide to stay in or leave rural and remote areas. These include personal and family factors, working and living conditions, career-related factors, financial aspects, and mandatory

rural service (Henderson and Tulloch, 2008). The Lack of health professionals in rural areas leads to delay in seeking care until the patient's condition deteriorates or worsens (Ebuehi, & Campbell, 2011).

During the last six years, the Ministry of Health (MoH) decided to increase its production of midwives from 2,000 per annum to 5,000 midwives (MoH CHPS Policy Guide, 2015). The reason for the focus on midwives was that there were few midwives in the country as compared to general nursing, and the midwives could play an active role in health care prevention than curative. The midwives are expected to provide health education, immunization, and antenatal care, among other things in the rural areas, just in line with the primary health care concept. Due to the high demand for midwives at the district and community level, fifteen (15) new health-training institutions have been established and existing once expanded to take in more health care professionals.

Given the expansion and establishment of health training institutions, 150 additional tutors in the various subject areas (anatomy, medicine, maternal and child health, and public health) are required to teach in the district capitals where new training institutions are located. The expansion involves an increase of intake from 2,000 trainees per annum to 5,000 trainees. Without having adequate numbers of qualified health tutors, the policy reforms of the Ministry of Health have implementation difficulties.

Health tutors are either general nurses, midwives, community health nurses, environmental officers, laboratory technicians, or disease control officers, but does not include the physicians. According to the Ministry of Health, a health tutor is a person with a background in health, practices for a minimum of three years in the clinical area, and has a minimum of a first degree and a certificate in education to enable the person to teach (MoH CHPS Policy Guide, 2015). Unlike the other health professional in the clinical area who could practice with a diploma, the

health tutor is expected to have a minimum of the first degree, and aside the teaching is expected to take part in clinical work when students go for clinical.

It is worth mentioning that in the past, health institutions were built in the regional and national capitals where tutors had better schools for their children, part-time work opportunities, and opportunities for further studies. The new reforms require new training institutions built in the districts. The district capitals have less opportunity for further education, less good schools, and fewer social amenities than the regional capitals. The health tutor needs to be motivated to teach at the various districts where there are fewer opportunities for themselves and their families. There is also the need to ensure that stay or be retained. Hence, this research will explore the key factors that are necessary to motivate the health tutor to teach and how best they can be kept in the district and sub-district, which are predominantly rural. The ministry needs to know what will motivate health tutors to teach in the rural area and retain them in the health-training institutions located in rural areas.

There are two types of tertiary institutions that pursue health programs: the universities that fall under the ministry of education and the health training institutions, which fall under the Ministry of Health. The universities offer health courses from degree up to the doctorate level. The Ministry of Health training institutions offers training certificates and diplomas for the health sector. There are 96 health-training institutions distributed across the ten regions of Ghana. Each regional capital has at least one nursing, midwifery, community health nursing, and a health assistant training school, making up 32 in the regional capitals. The rest of the 64 institutions are in the districts and sub-districts of the country.

Most of the districts and sub-districts are less developed than the regional capitals and have fewer social amenities than the regional capitals. Siting the health training institutions in the district capitals allows people from within the district and its localities to have access to the health training institution. Students admitted to health training institutions are mandated to stay

in the community to work for three years after completing their program. This policy is for only schools located in rural areas. The essence of this policy was to get more people from the districts, which are predominantly rural and understaffed, to stay and work after school (MoH CHPS Policy Guide, 2015).

Generally, for all students, the central government provides students with allowances to support them in books and transport to clinical sites. The essence of the financial support is to bond them to serve for a minimum of three years in the rural area, or five years in the city, before leaving the service, which is mandatory for all students in the ministry of health institutions, whether rural or urban. Poor students' records keeping makes enforcement of the policy tracking graduate students challenging. The other reasons for poor policy enforcement are favouritism, nepotism, and political interference from politicians who often break the rules.

The Ministry of Finance in Ghana annually allocates funds to the training institutions through the ministry of health to run the training institutions. The government pays tutors and other support staff in the schools through the controller and accountant general department of the ministry of finance. The central government provides training institutions with buses, pickups, and other logistics.

1.2.1 A General Overview of Ghana

This section provides an overview of the climate conditions, administrative regions, politics, and economy of Ghana. Following the outline is the context of the health systems relevant to the health training institutions in Ghana. Ghana is situated in the middle of the west coast of Africa and shares borders with three French-speaking countries. It is bordered to the north by Burkina Faso (formerly Upper Volta), to the west by Cote D'Ivoire, and the east by Togo; to the south of the country lies the Atlantic Ocean and the Gulf of Guinea (Figure 1). The

Greenwich Meridian, which passes through London, also traverses the country at Tema. Its total area is 238,540 square kilometers (91690 square miles) (Boateng, 1966).

The climate of Ghana is tropical. The country experiences two climatic seasons, the dry season and the rainy season. The rainy season lasts roughly from April to September, while the dry season lasts roughly from October to March. The northern part of the country experiences severe Harmattans (a desert-dry wind blowing from the northeast of the country lasting from December to March). The harmattan makes it difficult for some health workers from both the locality and the south do not want to stay there and work. Annual rainfall ranges from about 1100mm (43 inches) in the farthest northeast to about 2100 mm in the southeast with the average low temperature is 20.5 degrees celcius (69 dgrees fahrenheit), and an average high of a temperature is 26 degreees celcius (79 degrees fahrenheit) (Boateng, 1966:24-31). The northern part of Ghana is savannah grassland with few trees, while the middle of the country has a tropical rain forest.

The coastal regions also have savannah grassland. Like most developing countries, Ghana depends on agricultural production and primary exports. The coastal belt zone produces fish, staple foods such as maize, salt, pineapples, coconuts, cassava, palm oil, palm kernels, and poultry. Salt and fish are the main exports to neighbouring countries such as Burkina Faso, Mali and Niger. At the same time, palm oil is exported not only to neighbouring countries but also to some European Countries and America. The middle belt produces cocoa beans, timber, coffee, tobacco, palm oil, palm kernels, plantain, cocoyam, cassava, and maize. Cocoa and timber, as noted earlier, are significant sources of foreign exchange, and these are produced in the middle belt of the country. The northern belt of the country has shea nuts, cotton, cashew, fibres, peanuts, yams, millet, tomatoes, guinea corn, rice, and animal husbandry. Cotton, cashew, shea nuts, tomatoes, peanuts are cash crops grown in commercial quantities to feed cotton ginneries, shea butter processing plants, and other factories mostly located in the

northern parts of the country. The North remains the country's primary source of protein supply because of a climate favourable to cattle, birds, sheep, and goats.

Figure 1: Administrative map of Ghana



Source: Google Maps, 2016.

1.2.2 Overview of the Ministry of Health in Ghana

The Ministry of Health, in the past, held the responsibility of the direct provision of public health services delivery in the country. These responsibilities encompassed promotion, preventive, curative, and rehabilitative care. However, with the enactment of ACT 525, this function has been ceded to the Ghana Health Service (GHS) and Teaching Hospitals (THOSP).

The current mandate of the Ministry of Health is mainly on policy formulation, monitoring and evaluation, resource mobilization, and regulation of the health services delivery. Having ceded some functions to the Ghana Health Service, there was the need for restructuring the Ministry of Health to enable it to perform the role that it must play in response to the change that is taking place in the health sector. The basis of the restructuring is to ensure the effective performance of the Ministry's functions, avoid internal duplication of efforts, and conflict with the Ghana Health Service and Teaching Hospitals (MoH program of work, 2002-2006).

There are four main categories of health care delivery systems in Ghana – the public, private-for-profit, private-not-for-profit, and traditional systems (MOH, 1997). The health system revolves around the Ministry of Health. Administratively, it has a hierarchical organizational structure from the central headquarters in Accra (the capital city) to the regions, districts, and sub-districts. Services are delivered through a network of facilities, with health centres and district hospitals providing primary health care services, regional hospitals providing secondary health care, and two teaching hospitals at the apex offering tertiary services (Agyepong, 1999). The two teaching hospitals also play a crucial role in teaching and research – offering facilities for the training of physicians and other health professionals, and as well as medical and public health research (Govindaraj & Chawla, 1996).

The Ministry of Health is charged with regulating the entire health sector through its several policies. The primary function of the ministry is policy formulation, coordination, and regulation of the stakeholders in the health sector. In formulating such policies or guidelines for regulation, the ministry collaborates with various ministries, departments, and agencies (MDAs) and other partners and stakeholders in the health sector. According to the Second Five Year Programme of Work 2002-2006, the targeted MDAs are the Ministries of Education, Environment, Science and Technology, Works and Housing, and Local Government and Rural Development. The partners are also made up mainly of bilateral and multilateral donors, NGO's and civil society organizations. However, the implementation of the policies and the enforcement of its regulations are carried out directly and indirectly by such MDA's and other institutions working with the ministry (Ackon, 2003; Abekah-Nkrumah, 2005). Policy implementation is carried out through the public, private and traditional sectors. At the public sector end, the Ghana Health Service (GHS), Teaching Hospitals Board (THB), and the Quasi Government Institution Hospitals (QGIH) are the implementing agencies of the ministry.

The Ghana Health Service is responsible for implementing the government's health policy and regulation of state-run health institutions (i.e., GHSP – Government Hospitals, PC – Poly Clinic, HC – Health Centres). To carry out its functions, the Ghana Health Service has a secretariat that has been decentralized from the national level to the regions and the districts. At each level, there is a team of management that administers the affairs of the service. The districts report to the regions, and the regions report to the national level as stipulated in the Ghana Health Service and Teaching Hospitals Act (1996), Act 525. The Teaching Hospital Board (THB) is the institution responsible for implementing the government's health policy and regulation at the teaching hospital level. This institution was also established by Act 525. The last of the public sector agencies is the Quasi Government Institution hospitals (QGIH). This is currently an association and not a statutory body backed by relevant legislation. It is

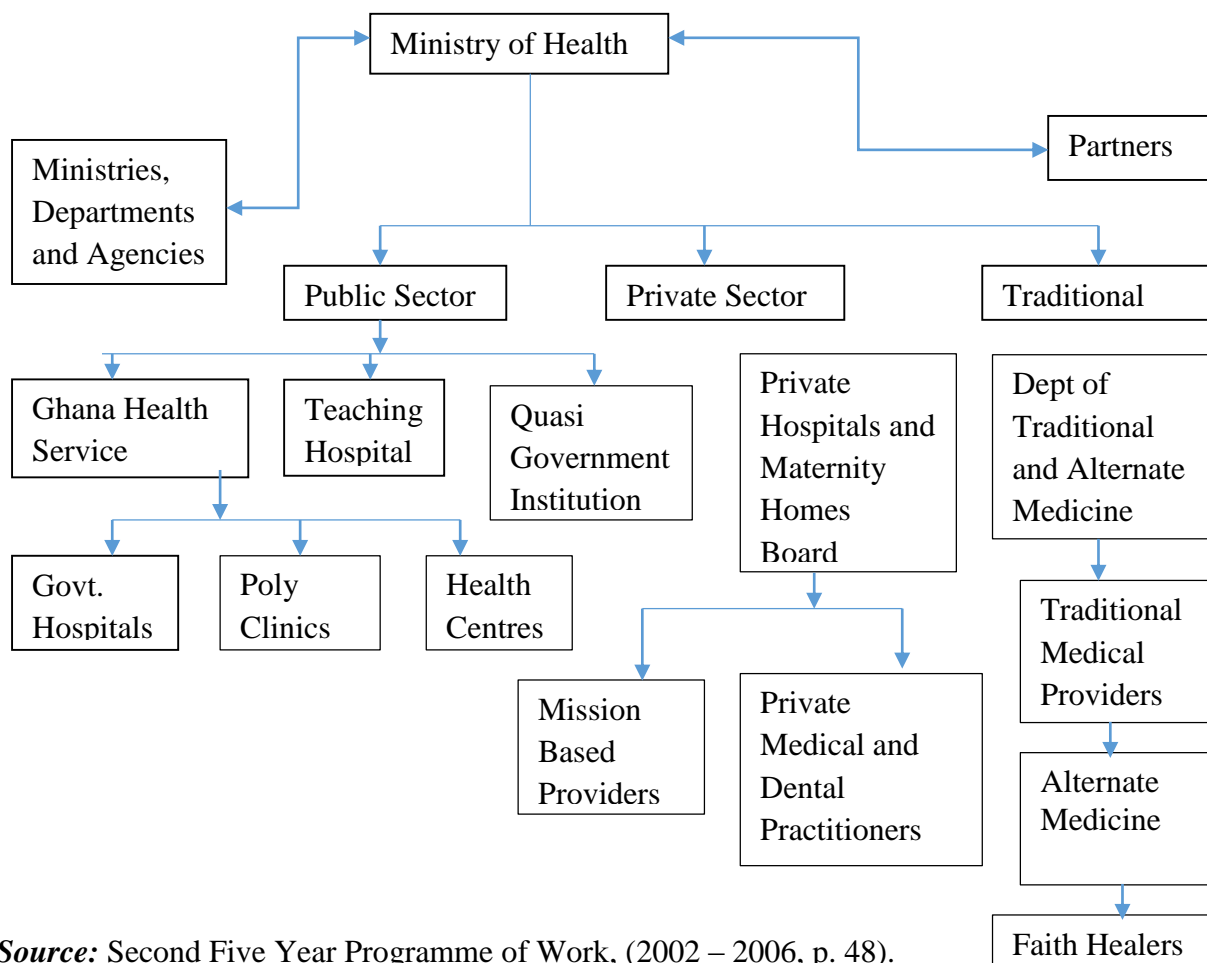
responsible for the implementation and regulation of hospitals owned by quasi-government institutions (Ackon, 2003; Abekah-Nkrumah, 2005). The private sector is also a significant player in Ghana's health sector, responsible for about 40 percent of total healthcare delivery (Abekah-Nkrumah, 2005). The main regulatory body for the private sector is the Private Hospitals and Maternity Homes Hospital governance in Ghana Board (PHMHB), established by Act- 9, 1958 as amended. The primary providers in the private sector are the Faith-based organisations (FBO), consisting of Christian and Moslem hospitals and private medical and dental practitioners. Finally, activities of the traditional sector are regulated by a directorate in the Ministry of Health. However, the institutional and legal framework necessary to carry out such work is currently not in place. The primary traditional healthcare providers in this sector are the Traditional Medical Providers (TMP), Alternative Medicine (AM) and Faith-based Healers (FH) (Ackon, 2003; Abekah-Nkrumah, 2005).

One important role the ministry of health plays in training is having direct oversight responsibility for the Ministry of Health Schools. These include determining the number of students to be admitted per year based on the vacancies available at the hospitals. Determining the number of tutors to be recruited, the number of staffs to be awarded a scholarship for further studies within the year, resources allocation, number of programs to be run by the school, promotions, and appointment of health tutors in the training school and other vital roles deemed necessary.

The health training institutions directly fall under the ministry of health, and therefore everything related to training the middle-level cadres of health professionals falls under the Ministry of Health. The faith-based organization, also known as mission-based providers (fig. 3), also owns training schools and provides middle-level training (diploma). The schools belong to the faith-based institution, but the Ministry of Health offers the policy directives. The ministry of health pays the faith-based institutions; provides them with buses, picks, and other

resources, just like the Ministry of Health institutions. The difference is only ownership. The faith-based institutions must help the Ministry of Health provide adequate staff for the country. In this study, it is worth mentioning that faith-based institutions were not part of this study because of ownership. Exempt from this study are nursing departments of public and private universities because they primarily come under the Ministry of Education.

Figure 2: Structure of the Health sector in Ghana



Source: Second Five Year Programme of Work, (2002 – 2006, p. 48).

1.2.3 Overview of the Ministry of Health Training Institutions in Ghana

The Ministry of Health currently regulates ninety-six health-training institutions located in all the ten regions of the country. These training institutions offer basic programmes in Nursing, Midwifery, Health Assistant, Community Health Nursing, Optics, Physiotherapy, Environmental Health, and Dental technology. The Ministry also has post-basic institutions

offering specialized programs in Public Health, Ear, Nose and Throat, Anaesthesia, Ophthalmic, Peri-Operative and Critical Care, Medical Assistants and Midwifery. The Rural Health Training institution in Kintampo has the most significant number of programs totalling eleven. It is the only institution among the health training institutions that run degree programs and different from the others. All the other training institutions are either at the certificate or diploma level.

Table 1: Overview of Health Training Institutions disaggregated by ownership

Types of Training Institutions	Ownership			
Physician Assistant Programme	2	-	-	2
Dentistry	1	-	-	1
Pharmacy	2	-	1	3
Nursing and Midwifery	28	3	2	33
Health Sciences	2	-	-	2
Community Health Nursing	11	1	-	12
Health Assistant Clinical	20	1	1	22
Post Basic Programmes	6	-	-	6
Allied Health Schools	11	-	-	11
Public and Environmental Health	3	-	1	4
Total	86	5	5	96

Source: Ministry of Health Human Resource for Health Development (HRHD), (2016).

A Training Unit under the Human Resource Directorate currently manages these health-training institutions at the Ministry of Health. This Directorate consists of other Units headed by a director, three deputy -directors, three administrative officers, two secretaries, and other staff. A deputy director manages all 96 health training institutions.

1.2.4 The Ministry of Health Training Programmes in Ghana

The Ministry of Health, through the health-training unit of Human Resource Directorate (HRD), runs different training programs in the country to prepare personnel for the provision of quality health care to people living in Ghana. The academic programmes are of two types, namely, Nursing Programmes and Non-Nursing Programmes. The nursing programmes prepare graduates to work in nursing-related fields. The Nursing and Midwifery Council of Ghana (NMC) regulate them. Every region has training institutions offering Registered General Nursing (RGN), Registered Midwifery (RM), Registered Mental Nursing (RMN) Community Health Nursing (CHN), and Health Assistant Clinical (HAC) programs. Except for the RMN, which is offered only in two regions (Greater Accra and Central regions). The Health Assistant Clinical (HAC) fall under nursing because they work under the direct supervision of the nurse and are supposed to assist the nurse.

Non-nursing programmes prepare graduates to work in other health-related fields, which are not directly related to nursing. Institutions offering these programs offer training in a wide range of allied and non-allied health fields such as physician assistantship, public health, environmental health, physiotherapy, and orthotics, optical, dental, and medical laboratory technology at the health training institutions under the ministry of health.

Apart from the categorization of health programs above, four categories of mainstream nursing programs are offered by health training institutions in Ghana. These programs are auxiliary, basic, post-basic, and bachelor's programs under the Ministry of Health. The auxiliary programs are designed to train non-professionals who mainly work under the supervision of health professionals. The programs are mostly for those who are applying with their Senior Secondary/Senior High School examination results and require no previous knowledge in any health-related field. However, experience in health (such as Health Extension Workers, NIDs volunteering, Ward Assisting, etc.) may give the applicant an edge during the interview and

selection process. Auxiliary programs run for two years, and successful completion leads to a certificate, depending on the type of program pursued.

Table 2: Auxiliary and certificate programmes

Program Name	Duration	Location	Type	Qualification Awarded
Optical Technician	Two years	Ashanti	Optics	Certificate
Community Health Nursing	Two years	All Regions (except Greater Accra)	Community Health Nursing	Professional Certificate
Environmental Health Assistant	Two years	Northern, Volta	Environmental Health	Certificate
Field Technician (Community Health)	Two years	Brong Ahafo	Public Health	Certificate
Health Assistant Clinical	Two years	All Regions	Health Assistant (Nursing)	Professional Certificate
Physiotherapy/Orthotics Assistant	Two years	Brong Ahafo	Physiotherapy /Orthotics	Certificate
Health Records Management	Two years	Brong Ahafo	Health Information Management	Certificate

Source: Ministry of Health, Human Resource for Health Development (HRHD), (2016)

The basic programmes turn out skilled health professionals who practice in various fields in the health sector. The programs are mainly for those applying with their Senior Secondary/Senior High School examination results and require no previous knowledge in any health-related field. Basic programmes are for periods ranging between three to four years. Successful completion leads to the award of a diploma or advanced diploma depending on the type of program pursued.

Table 3: Basic and Diploma programmes

Programme Name	Duration	Award	Location (Region)	Type
Community Medicine & Health Direct Entry	3 + 1 year Internship	Diploma	Brong Ahafo	Medical Assistant
Registered General Nurse (RGN)	3 + 1 year Internship	Diploma	All Regions	General Nursing
Registered Mental Nurse (RMN)	3 + 1 year Internship	Diploma	Greater Accra, Central	Mental Nursing
Registered Midwife (RM) Females only	3 + 1 year Internship	Diploma	All Regions	Midwifery
Registered Community Health Nurse (RCN)	3 + 1 year Internship	Diploma	Central, Upper East	Community Health Nursing
Technical Officer (Community Health Nutrition Option)	3 + 1 year Internship	Diploma	Brong Ahafo	Public Health (Nutrition)
Technical Officer (Community Health Disease Control)	3 + 1 year Internship	Diploma	Brong Ahafo	Public Health (Disease)
Technical Officer (Health Informatics)	3 + 1 year Internship	Diploma	Brong Ahafo	Public Health (Informatics)
Technical Officer (Health Promotion)	3 + 1 year Internship	Diploma	Brong Ahafo	Public Health
Technical Officer (Medical Laboratory Technology)	3 + 1 year Internship	Diploma	Brong Ahafo	Medical Laboratory
Environmental Health Officer	3 + 1 year Internship	Diploma	Greater Accra	Environmental

Source: Ministry of Health Human Resource for Health Development (HRHD), (2016).

The post-basic programs, on the other hand, build upon the basic programs by adding further knowledge and encouraging a focus on a particular area of study. Some post-basic programs lead to specialization in specific fields of health, such as public health, ophthalmic, anaesthesia, etc. In contrast, others give general knowledge in patient management and care (example is the Medical Assistant program). Applicants to post-basic programs usually require a minimum of three years of practical experience in a relevant primary area to qualify the individual to pursue the program. These programs range from 12 to 18 months, and successful completion leads to the award of an advanced diploma. Their employing agency should typically nominate applicants to post-basic programs (example of a GHS health facility). They will be required to return to their agency on successful completion for placement).

Table 4: Post-Basic and Advanced Diploma programmes

Programme	Duration	Award	Location	Prerequisite/Qualification
Community Medicine & Health (Post Basic Entry)	1.5 + 3 months Internship	Advanced Diploma	Brong Ahafo	General/Mental Nurse, Midwife/RCN
Community Oral Health and Medicine	1.5 + 3 months Internship	Advanced Diploma	Brong Ahafo	General/Mental Nurse, Midwife/RCN
Critical Care Nursing	1.5 + 3 months Internship	Advanced Diploma	Greater Accra	General/Mental Nurse, Midwife/RCN
ENT Nursing	1.5 + 3 months Internship	Advanced Diploma	Ashanti	General/Mental Nurse, Midwife/RCN
Anesthetist Assistant	1.5 + 3 months Internship	Advanced Diploma	Greater Accra	General/Mental Nurse, Midwife/RCN
Ophthalmic Nursing	1.5 + 3 months Internship	Advanced Diploma	Greater Accra	General/Mental Nurse, Midwife/RCN
Peri-Operative Nursing	1.5 + 3 months Internship	Advanced Diploma	Greater Accra	General/Mental Nurse, Midwife/RCN
Public Health Nursing	1.5 + 3 months Internship	Advanced Diploma	Greater Accra	General/Mental/Community Health Nurse, Midwife
Community Mental Health	Two years	Diploma	Brong Ahafo	Community Health Nurse, Field Technician, Health Assistant Clinical

Source: Ministry of Health, Human Resource for Health Development (HRHD), (2016).

Besides the mainstream nursing programmes, the Ministry of Health currently runs a Bachelors's degree programme in Medical Assistant Psychiatry. The College of Health, Kintampo, in collaboration with the Hampshire Foundation Trust and the University of Winchester in the United Kingdom, organizes the programme.

Table 5: Bachelor programmes

Programme Name	Duration	Location/Region	Prerequisite/Qualification	Qualification Awarded
Clinical Psychiatry	Two years	Brong Ahafo	Medical/Physician Assistant (Diploma)	BSc. University of Winchester
Dermatology and Venereology	Two years	Brong Ahafo	Medical/Physician Assistant (Diploma)	BSc. University of Utah

Source: Ministry of Health Human Resource for Health Development (HRHD), (2016).

1.2.5 Admission into Ministry of Health Training Institutions in Ghana

The nursing and non-nursing programs seek to maintain a transparent admission policy that specifies the process of student selection and the minimum acceptance criteria. Each program has a system that considers different entry points for students, such as applicants from senior secondary school or West Africa examination council. Below are the entry requirements for each level and the interpretation of the individual subject requirements of West Africa Senior Secondary School Certificate Examination (WASSCE) and the Senior Secondary School Certificate Examination (SSSCE).

Table 6: Admission requirements of various programmes

Entry Requirements for Certificate Programmes		
	WASSCE	SSSCE
Age	18 – 35 years	
Overall Aggregate	A cut-off aggregate score of 42 or better in 6 subjects comprising three core and three electives	A total cut-off score of 27 or better in 6 subjects comprising three core and three electives
Core Subjects and Minimum Grades	At least passes (A1-C6) in 3 core subjects. In other words, English, Mathematics, and Integrated Science.	At least passes (A-D) in 3 core subjects. In other words, English, Mathematics, and Integrated Science.
Elective Subjects and Minimum Grades	At least passes (A1-E8) in 3 elective subjects	At least passes (A-E) in 3 elective subjects
Entry Requirements for Diploma		
	WASSCE	SSSCE
Age	18 – 35 years	
Overall Aggregate	An aggregate score of 36 or better in 6 subjects comprising three core and three electives	A total score of 24 or better in 6 subjects comprising three core and three electives
Core Subjects and Minimum Grades	A1-C6 in 3 core subjects. In other words, English, Mathematics, and Integrated Science.	A-D in 3 core subjects. In other words, English, Mathematics, and Integrated Science.
Elective Subjects and Minimum Grades	A1-C6 in 3 elective subjects. Acceptable subjects are indicated in Appendix C	A-D in 3 elective subjects. Acceptable subjects are reported in Appendix C
Entry Requirements for Post Basic		
Programme	Service Requirement	Qualification Required

Anesthetist Assistant	<ul style="list-style-type: none"> a. At least one-year rotation/internship/national service. b. Two-years' experience in a relevant Basic area or one-year work experience upon a request from a facility after an internship. 	General Nurse Mental Nurse Midwife RCN
Entry Requirements for Bachelor's Degree		
Programme	Service Requirement	Qualification Required
Clinical Psychiatry	<ul style="list-style-type: none"> a. At least one-year rotation/internship/national service. b. Two years' experience in a relevant Basic area or One-year of work experience upon a request from a facility after an internship 	Advanced Diploma as a <ul style="list-style-type: none"> 1. Medical Assistant 2. Physician Assistant (Medical)

Source: Ministry of Health Human Resource for Health Development (HRHD), (2016).

The table below shows West Africa Senior Secondary School Examination Grades and their interpretation for admission into the various programmes mentioned earlier.

Table 7: West Africa Senior Secondary School exam grades

WASSCE	Grade	Interpretation
A1	1	Excellent
B2	2	Very Good
B3	3	Good
C4	4	Credit
C5	5	Credit
C6	6	Credit
D7	7	Pass
E8	8	Pass
F9	9	Fail

Source: Ministry of Health Human Resource for Health Development (HRHD), (2016).

The table below shows Senior Secondary School Certificate Examination grades and their interpretation for admission into the various programmes, as mentioned earlier.

Table 8: Senior Secondary School Certificate exam grades

SSSCE	Grade	Interpretation
A	1	Excellent
B	2	Very Good
C	3	Good
D	4	Credit
E	5	Credit

Source: Ministry of Health Human Resource for Health Development (HRHD), (2016).

1.2.6 The curriculum of the Health Training Institutions in Ghana

The curricula for the nursing and non-nursing programs in Ghana consider workforce planning flows and national health-care policies. Curricula, planned and designed to meet national and international education criteria and professional and regulatory requirements for practice, have

a demonstrated theoretical basis, and exhibit a balance of theory and practice. The focus of both classroom and clinical education is on the knowledge and practical skills needed to meet Ghana's population (Sue et al., 2014).

The curricula at each program demonstrate the core content that will enable graduates to meet the established competencies stated in the WHO Standards (2009) and includes material in nursing and non-nursing theory, practice, interventions, and scope of practice, given a review of course descriptions and schedules. Supervised clinical learning experiences that support the hypothesis are included in the practical portion of students' education (NMC, 2016).

1.2.7 Regulatory Bodies of Ministry of Health Training Institutions in Ghana

There are three central regulatory bodies for the health training institutions in Ghana. These are the Nurses and Midwives Council, the Allied Health Council, and the Medical and Dental Council of Ghana. Below are the brief details for each.

Nurses and Midwives Council of Ghana; The mission of the council is to secure in the public interest the highest standards of training and practice of nursing and midwifery. The council's vision is to ensure the availability of trained nursing and midwifery professionals who would give competent, safe, prompt, and efficient service for client delight. Currently, the Council regulates the following Nursing and Midwifery programs: Neuroscience Nursing, Palliative Care, Haematology Nursing, Well Woman Care – Advanced Midwifery, Neonatal Intensive Care, Oncology Nursing, Paediatrics Nursing, Emergency, Nurse Practitioner, Critical Care Nursing, Peri-Operative Nursing, Public Health Nursing, Ophthalmic Nursing, Ear, Nose & Throat Nursing, Community Psychiatric Nursing, Registered General Nursing, Registered Midwifery, Registered Mental Health Nursing, Registered Community Nursing, Post NAC/NAP Midwifery, Nurse Assistant (Preventive), Nurse Assistant (Clinical) (NMC, 2016).

Allied Health Professions Council; The Allied Health Professions Council is the body established by an Act of Parliament (Act 857, 2013) to regulate the training and practice of Allied Health Professions in Ghana. As part of its mandate, the Council is responsible for granting Professional Accreditation for all Allied Health Programmes. The council currently license the following programs: Audiology, dental health, dietetics, disease control, environmental health, health information and records management, health promotion, medical laboratory science, medical physics, medical radiation technology, mental health, nutrition, occupation therapy, optometry, physiotherapy, prosthetics and orthotics, speech therapy (AHPC, 2016).

Ghana Medical and Dental Council; The Ghana Medical and Dental Council is an agency of the Ghana government responsible for regulating the training and practice of medicine and dentistry in Ghana. The Medical and Dental Council is a statutory body responsible for securing in the public interest the highest level of training and practice of medicine and dentistry in Ghana. A Practitioner (doctor) is a person registered under the Medical and Dental Council Decree (1972) NRCD 91 to practice medicine or dentistry in Ghana (MDC, 2016).

1.2.8 Internships and National Service after school.

The internship is a time after formal training that students work under supervision. Interns must pass their academics in school and their professional examinations to qualify them for the internship. New qualified professionals would register with the National Service Scheme for the one-year rotation after they have passed their Licensure / professional exams. The regulatory body, health training institution, service site professionals, and the national service secretariat shall provide supervision for the internship period. The internship period ranges from 12 months to two years for health professionals. Interns shall be paid allowances by the national service secretariat. Graduates not satisfying the standard of the regulatory body may

be made to extend the internship until they are found competent. Internship allowances cease immediately after completion of the internship period.

1.2.9 Posting after Internship

Formal rules for decision-making authority for postings and transfers are cascaded down MOH and GHS lines. Each level, from MOH headquarters to GHS headquarters, to regional, district, and facility levels, has a different scope of decision-making authority regarding the posting and transfer of employees, generally related to the mandate of that level. Thus, MOH, as the coordinating body for the entire health sector, determines agency staff allocations and post staff to its agencies (such as the GHS). MOH has no formal posting and transfer powers within the agencies themselves. GHS headquarters determines staff quotas at the regional level and posts to regions, but has no posting and transfer powers to specific districts. GHS-HQ must be informed of the final postings and transfers within-region as part of its monitoring of staff distribution. If staff want to move from one region to another, they have to seek release from their region of work to GHS-HQ, and GHS-HQ confirms that there is a vacancy in the region the staff desires to move into before posting them. A region can refuse to release or accept staff. Similarly, the region posts to districts and is not supposed to interfere with facility posting within-district. Again, the district can refuse to release or accept staff.

The draft policy on postings (2015) identifies a policy goal of equitable staff distribution, focusing on posting staff to where their services are needed, according to district plans. The policy distinguishes between postings at headquarters, postings across and within regions, and across and within districts. Inter-regional postings are identified on regional needs and are the responsibility of either the director-general, director of human resources or regional directors of health services, depending on the category of staff. Postings across districts are the responsibility of regional directors. Postings within districts are the responsibility of district

directors. Therefore, it appears that the bulk of posting and transfer powers exists somewhere between the region and district. Staff distribution is meant to be done based on need, geographical access, and equity. The principle underlying posting is that staff are to be distributed solely based on vacancies, and they are to be done with fairness and transparency. The policy further recognizes that the lack of differential incentivisation across rural and urban settings contributes to the maldistribution of staff. The policy operates on a principle of train and retain, meaning that new graduates from MOH training institutions must serve in the regions where they were trained. Procedurally, it is the regional director who issues posting letters to staff with copies to the receiving district where the staff is meant to report to the district director. The district director then assigns staff to sub-district facilities. Heads of facilities report the assumption of the duty to the district when a staff has reported there. The policy denotes consideration of where spouses work as a privilege, not a right. (Kwamie et al., 2017).

1.2.10 Sources of funding for Health Training Institutions

Public health training institutions under the Ministry of Health have two sources of funding under the Ministry of Health. The first is funding provided by the Government of Ghana to pay for salaries of full-time employees, allowances for students, capital investments and sometimes some funds released periodically for the upkeep of the institutions. The second source of funding is internally generated funds (IGF). The IGF is from the school fees paid by students. The IGF is a primary source of financing for capital investment, maintenance, utilities, and another running cost for the institutions.

Faith-based health training institutions under the Ministry of Health draw their funds from three sources. The first is donations in cash and kind from the church or faith-based organization establishing the training institution. The government of Ghana supports the faith-based health

institutions with funding to pay salaries of employees, allowances for students, capital investments, and periodically for the general sustenance of the institution. The third source of financing is IGF.

Private-for-profit health training institutions do not receive any funding support from the government of Ghana. Their primary source of funding is the internally generated funds from school fees paid by students.

1.3 Problem Statement

A significant challenge faced by health training institutions in Ghana is the migration of health tutors from rural to urban health training institutions. Annually, an estimated 30% of health tutors in Ghana's rural areas request transfer to urban health training institutions (Ministry of Health, 2015). These transfers end up creating a disproportionate tutor to student ratio between rural and urban health training institutions and potentially affecting the performance of health training institutions in the country. The availability of better working conditions and career prospects, including avenues to earn extra income outside regular monthly salary and opportunities to pursue a higher educational qualification in universities that are non-existent in rural areas is a significant pull factor (Agyapong et al., 2004; Johnson et al., 2011; Alhassan et al., 2013).

In addition to the migration of health tutors from rural to urban health training institutions, there is also the issue of health tutor migration from health training institutions under the ministry of health to other institutions that pursue health programs. The other institutions that seek health training programs are the universities that fall under the Ministry of Education. The migration of tutors from rural to urban within the Ministry of Health and from the ministry of health to the Ministry of Education adversely affects the standard staffing norm target of 1:5 set by the Ministry of Health for the health training institutions. The tutor to student ratio in a

typical rural health training institution is 1:30 compared to that of the urban, which is 1:10 (Ministry of Health, 2015).

1.4 Purpose Statement

The purpose of this mixed methods study is to examine how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana. An exploratory sequential design was used first to explore qualitatively to develop a context-specific and sensitive quantitative survey instrument to be administered to a large sample of tutors in public health institutions in Ghana. The first phase of the study was a qualitative study to explore how tutors of public health training institutions were motivated and retained at their posts in a rural and urban area in Ghana. In the exploratory study, interview data were collected from tutors at a rural and urban public health training institution. From this initial exploration, the qualitative findings were used to develop assessment measures administered to a large sample. In the quantitative phase, survey instrument data was collected from the tutors of public health institutions in a rural and urban area of Ghana to examine how the tutors are adequately motivated and retained.

1.5 Overview of Theoretical Framework and Methodology

The theoretical framework is the structure that can hold or support a theory of a research study. It introduces and describes the theory which explains why the research problem under study exists.

1.5.1 Overview of Theoretical Framework

This section provides an overview of the theories that will serve as a lens for interrogating how tutors of public health institutions are motivated and retained at their posts in rural and urban

areas of Ghana. A theory is a set of related constructs or principles, propositions, and definitions that presents a well-organized view of a phenomenon (Kerlinger, 1979). Various reasons have been given to why workers leave one employment for another. Issues of job satisfaction and the need to meet man's physiological and psychological needs were some of the reasons for workers quitting their jobs (Samuel & Chipunza, 2009). Herzberg's motivation-hygiene theory is useful in explaining the reasons why employees are motivated to continue working in a particular position.

Herzberg's motivation-hygiene theory. Based on their famous study of engineers and accountants, Herzberg and his colleagues (Herzberg, Mausner, and Snyderman, 1959) developed the theory of motivation and job satisfaction known as the Herzberg motivation-hygiene theory, or two-factor theory, or dual-factor theory, or Herzberg's theory. The theory has several assumptions. First, there are two separate sets of factors in explaining work satisfaction and dissatisfaction. Second, motivators tend to produce satisfaction, and hygiene factors tend to produce dissatisfaction. Third, work satisfaction and dissatisfaction are not opposites but separate and distinct dimensions (Herzberg, 1971).

The theorists postulated that when certain human needs referred to as motivators (recognition, work itself, achievement, advancement, and responsibility) are met, satisfaction is increased. On the other hand, when factors referred to as hygiene (supervision, salary, working conditions, interpersonal relations, policy and administration, and personal life) are not gratified, negative attitudes are created, leading to job dissatisfaction. However, the satisfaction of hygiene factors leads to only minimal job satisfaction (Herzberg, 1971). Herzberg & Jungen (1982) asserted that factors that promote positive job attitudes (motivators) do so because of their potential to satisfy psychological growth or what Maslow refers to as self-actualization. On the other hand, hygiene factors promote the satisfaction of physiological, safety, and social needs.

This researcher used the variables that constitute Herzberg's two-factor theory to examine how the variables account for the job satisfaction of research participants and their decision to move from a public health training institution in the rural area to that of an urban area. The variables of the two-factor theory would be used in the quantitative segment of the study to determine which factors create job satisfaction and the motivation to stay in a rural area public health training institution, and which factors serve as a disincentive to stay.

Equity theory. John Stacy Adams, a workplace psychologist, developed the equity theory in 1963. The equity theory is also known as the equity theory of motivation. The theory focuses on worker perception of fairness. According to the equity theory, employees are motivated by fairness in the workplace and working conditions (Al-Zawahreh, & Al-Madi, 2012; Adams, 1963, 1965; Nohria et al., 2008). Impliedly the equity theory is based on the idea that employee adjusts to their work when they discover unfairness of working conditions between themselves and a fellow worker. Employees adjust to make the situation look fair according to their judgment (Al-Zawahreh, & Al-Madi, 2012; Adams, 1963; Nohria et al., 2008). A key concept in equity theory is procedural justice, which refers to the perceived fairness of the procedures used to allocate resources (Greenberg & Colquitt, 2005). For instance, if an employee discovers a peer gets paid more than what he receives as a salary for the same job, the employee would perceive this treatment as an unfair practice.

Inferences from the equity theory reveal that the more employee is treated by their employer fairly or equitable in the workplace; the more they are motivated to work hard or remain in the job (Al-Zawahreh, & Al-Madi, 2012; Adams, 1963; Nohria et al., 2008). In contrast, the employee is demotivated if they perceive unfairness in the workplace (Al-Zawahreh & Al-Madi, 2012; Adams, 1963; Nohria et al., 2008). The fundamental question of equity theory is what goes into a perception of inequity? The theory postulates that the critical mechanism for deciding whether an issue is fair or not is referred to as social comparison. The worker

compares himself with others regarding all that he contributed to the work in the form of inputs and all the rewards he received in the form of outputs. The theory further asserts that if the input/output ratios are the same for those in the group, then the treatment is fair (Adams, 1963). Perceptions of inequity interfere with worker motivation, and to reduce such perceptions of injustice, workers adopt one of the following three ways: try to increase their outcomes by seeking increased benefits such as a pay increase or other reward; try to quit the job and find another job; or reduce inputs by expending fewer efforts on the job (Baron, 1998).

Equity theory is a fundamental theory explaining how workers compare themselves with other workers doing the same job. The theory also provides an excellent framework for explaining worker motivation to retain a job or quit and find another job. The equity theory neatly fits the study on how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana. The equity theory would provide the theoretical lens to examine how tutors at rural public health training institutions socially compare themselves to their counterparts in the urban areas. Secondly, the theory serves as a lens to determine how health tutors in rural areas perceive themselves compared to those in the urban areas and vice versa.

1.5.2 Overview of Methodology

The study used a mixed methods design. Johnson, Onwuegbuzie, and Turner (2007) asserted that mixed methods studies combined elements of qualitative and quantitative research approaches (an example is the use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration (p. 123). Creswell and Plano Clark (2018), suggested that using a mixed methods approach was valuable when the collection of one type of data may not provide the information needed to answer the study's research question. Johnson and Onwuegbuzie (2004)

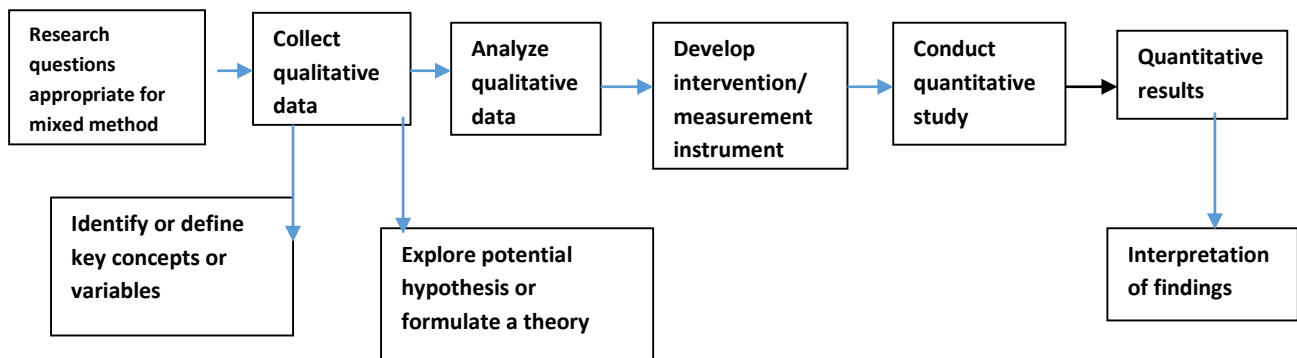
indicated that the use of mixed methods permitted researchers to design research to provide the researcher with the best opportunity to explore a research question.

Specifically, this study used the exploratory sequential mixed methods approach. An exploratory sequential mixed method design first gathers qualitative data to guide quantitative research (Privitera & Ahlgrim-Dezell, 2019). The intent of an exploratory sequential mixed methods model was grounded in the development of quantitative measures such as surveys in qualitative data (Creswell & Plano Clark, 2018). The purpose of collecting the qualitative data first is to ground the quantitative measures in the culture of research participants in order to see the measures as relevant (Creswell & Clark, 2018). The reason why the design is called exploratory sequential mixed methods is that qualitative study is best suited for exploring a phenomenon (Creswell & Plano Clark, 2018). The design is useful when measures, instruments, or experimental activities are not available, or variables are not well defined, or there is no theoretical framework, or there is a need to make an instrument specific to the participants' culture as possible (Creswell & Plano Clark, 2018). The exploratory sequential mixed methods design was used to make the variables of the research study culturally relevant to research participants.

This study sought to examine how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana. Using an exploratory sequential mixed methods design would enable the researcher to gain more in-depth insight into the topic. By exploring the research phenomenon first using a qualitative approach, the researcher used the quotes, codes, and themes from the data analysis to develop a culture-specific survey instrument that is relevant (Creswell, 2014). The extracts from the qualitative study were used to write the survey items, and the codes will be used to develop the variables that group the items, and the themes would be used to group the codes into measurement scales (Creswell,

2014). Captured in Figure 1 is the detailed procedure for the exploratory sequential mixed methods design. Figure 1 is adopted from Privitera and Ahlgrim-Dezell (2019).

Figure 3: Procedure for Exploratory Sequential Mixed Methods Design



Source: Privitera and Ahlgrim-Dezell, (2019).

1.6 Research Questions

The overarching research question of this study is; how are the tutors of public health training institutions motivated and retained at their posts in a rural or urban area of Ghana?

The specific research questions of the study are:

1. What are the factors that motivate the tutors of public health training institutions into tutorship in Ghana?
2. What are the factors that motivate the tutors of public health training institutions to stay at their posts in a rural or urban area of Ghana?
3. How equitable do tutors bring the inputs to public health training institutions and the outcomes they receive in a rural or urban area of Ghana?
4. To what extent and in what ways does the quantitative results confirm the qualitative data that tutors from urban public health training institutions are better motivated, equitably resourced, and retained at their posts than their counterparts in the rural areas?

1.7 Assumptions of the Study

Assumptions of a study are elements that are accepted to be true relative to the study (Roberts, 2010). This study has three premises. First, this study assumed that participants in both the qualitative and quantitative segment of the study answered the interview and survey questions honestly and accurately. The researcher believed that the tutors in the exploratory interviews would provide thick and rich descriptions of how they were motivated and retained at their posts. Further, it is assumed that although the issues of motivation are sensitive, the tutors would not be afraid to speak openly about their experiences. The researcher finally assumed that participants from the selected rural and urban areas for the quantitative segment of the study would be a representative sample of the conditions of tutors of public health training institutions in rural and urban areas of Ghana.

1.8 Delimitations and Limitations of the Study

1.8.1 Delimitations

The delimitations of a research study are the boundaries that are intentionally placed by the researcher to focus on the scope of the study (Roberts, 2010). The first delimitation was the choice of the research design of an exploratory sequential mixed methods study. By conducting an exploratory qualitative study first, the study was delimited to a few research participants who provided a context-specific understanding of how tutors of public health training institutions are motivated and retained in a select rural and urban area of Ghana. The criteria used to select research participants for the qualitative segment of the study was a delimitation (Roberts, 2010). Using a purposive sampling technique ensures that a thick and rich description of data is collected from research participants (Patton, 2015). Purposive sampling requires that only participants with in-depth knowledge about tutor motivation and retention were interviewed (Smith et al., 2009). Another method-based delimitation was the choice of

interviewing protocol deployed for the collection of the exploratory qualitative study (Smith et al., 2009). The study was also delimited by the data collection sites selected for inclusion. A rural and urban site was chosen first to collect the exploratory qualitative data, followed by the administration of a survey for comparison and extrapolation to the entire population of public health training institution tutors. Finally, the study was delimited by the concepts of worker motivation, retention, and equity, which are theoretically framed by Herzberg's motivation-hygiene theory, Maslow's hierarchy of needs theory, social exchange theory, and equity theory.

1.9 Significance of the Study

The significance of a study produces a clear and concise rationale for the worth of research and its application by various audiences (Roberts, 2010). The section explains why the study adds to the body of knowledge generally and specifically to improve practice, policy, or decision making (Creswell, 2014). A review of literature on health tutor motivation and retention from 1980 to date showed a lack of information on health tutor motivation, retention, and equity in rural and urban areas of Ghana compared to the general literature on health worker motivation and retention. The lack of empirical work on health tutor motivation and retention in Ghana gives impetus to the focus of the current study. The findings of this study will extend the limited knowledge on the topic area in Ghana and link it to the global literature on this theme, providing a basis for health sector human resource experts to revisit the entire staff motivation policy in the health training institutions.

This study adds to the body of literature on the subject matter. Policymakers in public health and governments would find this study useful. It would provide them with information on contemporary motivating factors that encourages tutors, particularly in rural public health training institutions, to decide to stay at their posts in light of the hardships they face. The study would provide policymakers in health and government officials with needed information on

how to motivate and retain health workers in rural localities. The study would also provide them with an understanding of the inputs invested by tutors of public health training institutions into their teaching assignments and the outcomes they expect. Additionally, the study would provide vital information on how to incentivize and equitably treat public health training institution tutors in rural areas like their counterparts in the urban areas.

This study would provide the information needed by public health policymakers in Ghana and the Ministry of Health. The results of the research would address the motivation, retention, and equity needs of human resources for health as expressed by the World Health Organization in their 2016 report dubbed *Global strategy on human resources for health: Workforce 2030*. The World Health Organization report of 2018 asserted that strategies on attraction and retention policies, a manageable workload, continuing education and professional development, family and lifestyle incentives, hardship allowances, housing and education allowances, adequate facilities and working tools, and equitable deployment of health workers to rural and underserved areas should be implemented (WHO, 2016).

The WHO actively advocates an evidence-based approach to health policy as a strategy to ensure policies are adequate, relevant, and sustainable in the long term (WHO, 2014). Research studies on the motivation of health tutors are valuable in forming a strong basis for dialogue and deliberations on sufficient health tutor motivation and retention policy in the health training institutions. The focus of this study is relevant to the current health sector human resource framework stipulated in the Ghana Health Service/Ministry of Health Human Resource Strategic Plan (GHS HSHR Report, 2015). The human resource strategic plan of the Ministry of Health recognized the need for an evidence-based approach to improving staff motivation and retention. Finally, the focus of the study on public health training institutions in rural and urban locations makes the outcome of the study relevant to significant stakeholders in the

health sector. The research is consistent in terms of equity in resource allocation and distribution to address the current rural-urban developmental gap in the country.

1.10 Organization of the Study

This study is organized into seven chapters. The introduction chapter provides information on the background and contextualization of the research issue, the research problem, the purpose of the study, an overview of the theoretical framework and methodology, the research questions, the significance of the research, and the definition of terms used about this study. Chapter two is dedicated to reviewing the literature on the theoretical frameworks used to frame the study. A review of the topical literature follows the theoretical literature review. Chapter three discusses the methodology of the study. It starts with a description of the research design, the research population, participants selection processes, the research site, the data collection processes, ethical considerations, credibility and reliability issues, researcher positionality, and data analysis processes. Chapter four presents the findings of the study. Chapter five discusses the results on the motivation of tutors of public health training institutions to continue in their posts. Chapter six discusses findings on the retention of tutors of public health training institutions at their positions. And chapter seven discusses the conclusions of the study.

1.11 Chapter Summary

This study aimed to examine how the Ministry of Health motivate and retained public health institution tutors in both rural and urban areas in Ghana. The motivation or lack of health tutors to migrate from rural to urban areas of Ghana informed this study. This study, an exploratory sequential design that will use a qualitative research method to develop a context-specific and sensitive quantitative survey instrument to be administered to a large sample of tutors in public health institutions in Ghana. The researcher used exploratory sequence mixed methods design

to examine how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana.

Herzberg's motivation-hygiene theory and equity theory served as the theoretical frameworks for this study. The motivation-hygiene theory asserts that motivating factors increase job satisfaction, and lack of gratification of hygiene factors leads to job dissatisfaction. The two theory constructs were used to guide the formulation of the quantitative instruments that sought to examine factors that motivate health tutors to leave their posts in the rural areas for greener pastures in the urban areas. The equity theory of motivation explains how workers compare themselves with other workers doing the same job. The theory also provides an excellent framework for explaining worker motivation to retain a job or quit and find another job. The theory serves as a lens to determine how health tutors in rural areas perceive themselves compared to those in the urban areas and vice versa.

The researcher assumed that the tutors in the exploratory interviews would provide thick and rich descriptions about how they were motivated and retained at their posts. Furthermore, it was considered that although the issues of motivation are sensitive, the tutors would frankly share their experiences. The exploratory sequential mixed methods section was limited to a few research cases in the first part of the study. The scope of the quantitative segment of the study was limited to only one rural area and one urban area due to time and resource constraints.

A review of literature on health tutor motivation and retention from 1980 to date showed a lack of information on health tutor motivation, retention, and equity in rural and urban areas of Ghana compared to the general literature on health worker motivation and retention. This study is, therefore, critical in several ways. The findings of this study will add to the body of knowledge on health worker motivation and retention. It would provide policymakers with information on motivating factors that encourages tutors, particularly in rural public health training institutions, to decide to stay at their posts in light of the hardships they face. The focus

of this study is relevant to the current health sector human resource framework stipulated in the Ghana Health Service/ Ministry of Health Human Resource Strategic Plan (GHS HSHR Report, 2015). The human resource strategic plan of the Ministry of Health recognized the need for an evidence-based approach to improving staff motivation and retention.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This section is in two parts. The first part of the review is on topical literature. Reviewed was the literature on three thematic areas of motivation, retention and equity. On motivation, the review covers types of motivation, intrinsic and extrinsic motivation, factors that affect motivation, job design and working environment, performance management systems, training, and development of workers. The review covers retention management, retention factors for employees, learning and working climate, job flexibility, superior-subordinate relationship, and employee motivation. The equity review was on promoting equity in the workplace. The second section of the literature review focusses on the theories that serve as the theoretical frameworks for this study. The study used the Two-factor Theory of Herzberg and Equity Theory as theoretical frameworks to guide the study.

2.2 Topical Literature Review

2.2.1 Motivation

The most valuable asset of an organization is its human resources. Every organization, whether it is public or private, worries about measures to put in place to attain a sustainable desired level of performance through the efforts of its employees. Establishing performance measures at the workplace means paying considerable attention to how people can be satisfied through such means as incentives, leadership, rewards, and the prevailing circumstances at their workplace (Amstrong & Taylor, 2020). The concept of motivation is primarily concerned with reasons why people behave the way they do in all situations (Osabiya, 2015). Generally, motivation can be described as the direction and persistence of action (Osabiya, 2015, p. 63).

Again, it has to do with why individuals decide on a specific course of action and hold on to the chosen action over time, even in times of problems and difficulties (Mullins, 2007). Therefore, motivation serves as a ground for innovation and productivity in any organizational establishment (Bloisi et al., 2003).

Motivation as a broader concept has received massive attention from numerous scholars and psychologists. The idea has been defined by Jennifer and George (2006) as an inner strength that governs people's behavioural patterns and directions in an organization, intensity of individual effort and an individual's level of commitment in the face of challenges and obstacles. The authors again added that, though the organization may have in place appropriate administrative structures and strategies, it will still need a highly motivated workforce to push the agenda of the organization to increase the level of productivity. For this reason, James and Stoner (2009) thought of motivation as the psychological features of people that raise their commitment levels towards a specific task or goal. It includes several elements that provoke, direct, and strengthen a person's behaviour in a particular way. Therefore, they concluded that motivation is a set of factors that influence employees performance and organizational productivity (James & Stoner, 2009).

According to Rehman et al. (2014), motivation is a fundamental aspect of any goal achievement process. That is the need that pushes people to participate in any goal-achieving program or activity. Given this, Beach (2005) believed that motivation relates to a person's readiness and enthusiasm for certain behaviours toward accomplishing a specific task. He again added that the ambitions, wants and needs of people tend to influence and control their behaviour toward particular goals (Beach, 2005). Davies (2005) asserted that the entire concept of motivation centres on what happens inside an individual that produces certain conduct and behaviour. In an organizational context, Davidson (2005) maintained that lack of motivation is enough to

explain employees dissatisfaction and disaffection with work. To Singh (2016), Motivation is considered to be the driving force behind an individual engaging in any activity (p. 198).

The above descriptions and definitions of the concept of motivation indicate that motivation, in general, is fundamentally associated with those elements and forces that cause specific human behaviours and actions (Beach, 2005; James & Stoner, 2009; Jennifer & George; Singh, 2016). Again, motivation can be summarized that designing a work environment with motivation at the centre positively influences employee performance and organizational productivity (Koontz, 2008; Osabiya, 2015; Singh, 2016). That is to say, motivation typifies employees and organizational behaviour, and as such, a high level of motivation increases the productivity level of employees to give out their maximum best towards the achievement of the organizational goals. Notwithstanding, creating a motivation-centred work environment also comes with its challenges. This problem is brought about due to the simultaneous increase in both organizational productivity and employee motivation. Thus, an increase in the level of the organization's productivity causes an increase in employees motivation.

Perceiving the impact of motivation on the workforce is a critical stride toward developing a positive work environment that improves the quality of the workforce. According to Ghaffari et al. (2017), motivation encourages a higher quality of human resources and promotes higher fulfilment in organizations. Therefore, motivation is what a person needs to display performance and readiness and apply effort (Ghaffari et al., 2017). Nevid (2011) asserted that motives are the rationale behind human behaviour: the wants and needs that control and explain our actions. Hence, the concept that underlies motivation is the power within people that drives them to attain a specific goal to fulfill their needs and expectations (Osabiya, 2015). The success of an organization is highly determined by employees being motivated to put up their best in terms of abilities and talents and satisfactorily directed to work on the right task (Osabiya, 2015). Mullins (2007) explained that the main grounds for productivity loss in most

organizations is a mediocre employee working morale, which includes low motivation, low respect, and recognition, lack of positive team spirit, reduced sense of belonging, etc. When organizations put in place positive motivation practices and mechanisms, service quality and productivity will be improved because motivation drives individuals to work towards achieving goals, acquiring a positive standpoint, establishing high self-esteem, and managing their abilities and capabilities (Osabiya, 2015).

2.2.2 Types of Motivation

According to Lin (2007), motivation can either come from within (intrinsic) or without (extrinsic). Naturally, motivation in the workplace is intrinsic or extrinsic (Martocchio, 2006; Singh, 2016).

Intrinsic motivation. This class of motivation comes from within the person (Martocchio, 2006; Singh, 2016). According to Legault (2016), intrinsic motivation refers to engagement in behaviour that is inherently satisfying or enjoyable... and as such, intrinsically motivated action is not contingent upon any outcome separable from the behaviour itself. Rather, the means and end are the same (p. 1). Intrinsic motivation is the doing of an activity for its inherent satisfaction (Ryan, 2016) or performing an activity for the pleasure inherent in the activity (Story et al., 2008, p. 707). A study conducted by Lee, Yun, & Srivastava (2013) revealed that intrinsic motivation is mainly a compounded neurophysiological activity in which a person undergoes a rigorous psychological process that springs from innate feelings. For that reason, intrinsic motivators can be explained as an inner feelings or sentiments people get from performing a purposeful task and doing it well (Kuvaas et al., 2017; Legault, 2016; Singh, 2016).

In organizations and workplaces, intrinsic motivation stems from desires and instincts characterized by the task or the work itself. Such motivation includes recognition, giving

responsibility, demonstrating abilities and expertise, freedom, and mutual respect. George and Jones (2012) maintained that an intrinsically motivated employee would be committed to his assigned job as far as the job gives him greater satisfaction he wants. Also, employees develop an intrinsic work behaviour towards a particular task not to seek external rewards, but because of the inner satisfaction upon successful completion of the job.

According to Zhang (2010), intrinsic motivation has consistent influences on creative-ability and innovativeness. Intrinsically motivated workers employ themselves in a task-role because they have a self-interest in their mission roles. Such employees/workers take pleasure in their jobs, hunt for new substitute ways of tackling job challenges. Thus these workers are most in all probability anticipated to go an additional mile to recognize shortcomings and find groundbreaking ways out (Cooper & Jayatilaka, 2006). Muhammad et al. (2016) posited that intrinsic motivation originates from assenting response towards jobs, action, facial appearance and others. Muhammad et al. (2016) revealed exciting work, job appreciation, job satisfaction, and stress reduction as intrinsic motivation factors. Enjoyment in tasks and behaviour gives workers an intelligence of appointment in the role, rather than merely moving out organizational operations.

Extrinsic motivation. Legault (2016) referred to extrinsic motivation as instrumental motivation or noninherent motivation (p. 1). According to her, extrinsic motivation refers to the performance of a behaviour that is fundamentally contingent upon the attainment of an outcome that is separable from the action itself (Legault, 2016, p.1). Also, the instrumental nature of extrinsic motivation is such that it is carried out to achieve some other reward (Legault, 2016). For example, a child may clean his or her parents room to be given an allowance. Likewise, a student will study hard for an exam all because of grade A. London (2009) also defined extrinsic motivation as performing an activity for the sake of the reward it brings. The extrinsic motivation means that external rewards or encouragement are received

from doing a job rather than real satisfaction of the post itself (London, 2009). Extrinsic rewards are mainly monetary and are the material prizes or awards employers and superiors give employees, for example, bonuses, benefits, and promotions (Legault, 2016; Singh, 2016). According to Singh (2016), monetary reward is not the sole motivator of extrinsic motivation. Other factors like work, organization characteristics, advancement opportunities, and job security are also classified as extrinsic motivators (Kuvaas et al., 2017; Legault, 2016; London, 2009; Singh, 2016). Extrinsic motivators cause individuals not to focus on the work itself well but to focus on doing that required to earn the reward (Singh, 2016). For instance, organizational promotions and other honours can increase intrinsic motivation, but in real terms, the original motivators are all extrinsic (Cooper & Jayatilaka, 2006). Therefore, extrinsic motivation causes individuals to work extra hard to receive the prize, reward, or award attached to a particular activity or task (Kuvaas et al., 2017; Legault, 2016). It is somewhat true that employees may not prefer performing specific tasks, but additional incentives and rewards that come with those tasks may inspire employees to do them. Therefore, George and Jones (2012) concluded that an extrinsically motivated employee would be committed to working extra hours on a task once it will earn him an external reward.

2.2.3 Factors Affecting Teachers' Motivation

Rasheed et al. (2016), in their work, elaborated compensation, job design and working environment, performance management system and training, and development as factors that affect teacher motivation.

Compensation Package. Compensation refers to benefits in the form of cash or in-kind that organizations give to employees in exchange for their contributions and efforts rendered to the organizations (Hamidi et al., 2014). Compensation mostly satisfies employees psychological, material, and social needs (Altinoz et al., 2012). Remuneration with overall satisfaction, but it

relates more closely to pay satisfaction (Lumley et al., 2011). Also, fringe benefits are indirect forms of compensation given to an employee or group of employees per their standing as the organization (Hornung et al., 2010). The authors again mentioned pension and retirement plans, educational reimbursement, medical insurance, and time off as some examples of fringe benefits (Hornung et al., 2010).

Bohlander et al. (2001) emphasized that administrators and managers of educational institutions should make compensation packages for teachers a topmost priority since it increases the motivation of teachers. In their view, compensation packages should be planned to meet the desired needs of teachers, as the tangible nature of these rewards highly motivate employees. Adding to that, Marlow et al. (1996) also discovered in their study that low remunerations increase the stress levels of teachers in educational institutions. After extensive investigation into the issue, Marlow et al. (1996) concluded that salaries paid to teachers should be competitive per the market standard to increase their level of motivation and keep them in the educational sector. Again, Litt and Turk (1985) perceived that one key issue that compels employees to quit their job is low income or salary. For this reason, they suggested that teachers' compensation packages should be well designed and properly managed.

Job Design and Working Environment. In Human Resources Management, job design has, over the past decades, received considerable attention from researchers. Research has shown that well-designed jobs attract the attention and interest of workers as individuals become bored with poorly designed jobs (Ebrahim & Zakaria, 2019; Parker, Wall & Cordery, 2001; Tsuma & Omondi, 2015). Therefore, increased workload and co-curricular activities are major problems teachers face in their job design (Davidson, 2005; Harun et al., 2015).

Besides, Clarke and Keating (1995) supported that a poor working environment in educational institutions decreases teachers motivation. Their research discovered that the critical determinant of teachers motivation is the students they teach. Therefore, hardworking and

gifted students increase teachers motivation, but they become less motivated when they meet students who are not able to display desired outcomes. Moreover, Clarke and Keating (1995) asserted that teacher-to-student ratio is another critical factor educational administrators and managers must consider in teachers motivation because a higher number of students in a class cause too much stress to the teacher. Above all, Ofoegbu (2004) suggested that educational institutions be provided with resources such as computers and internet access, finances for workshops and conferences, and modern library facilities since they serve as important motivators for teachers.

Performance Management System. Educational administrators and human resources managers should apply a present-day performance management system to evaluate the accomplishments and achievements of teachers. Stafyarakis (2002) believed that the application of Annual Confidential Reports for appraising employees is outmoded. Therefore, modern approaches based on scientific methods should be used to evaluate the performance of teachers. Milliman (1994) acknowledged the presence of many different techniques in the field, and he recommended a 360-degree feedback approach as the most effective appraisal method for teachers.

Adding to the same findings, Rao (2004) discovered in his study that teachers get greater satisfaction with intrinsic factors associated with their job than the monetary incentives that come with teaching. Again, Rao found that substandard appraisal systems, absence of respect, and recognition from both superiors and colleagues promote de-motivation and distress among teachers in the field. Also, Stafyarakis (2002) mentions that one main reason teachers leave their area is the lack of recognition from heads of educational institutions. For this reason, he emphasized that proper recognition, which is based on performance, should be given to teachers to boost their morale (Stafyarakis, 2002). Studies have shown that students feedback is of more significant concern to teachers (Baker, 2014; Hyland & Hyland, 2019; Rasheed et

al., 2010). Therefore, proper weightage should be given to students feedback in managing and appraising the performance of teachers in educational institutions (Rasheed et al., 2010). Jordan (1992) also acknowledged how students feedback helps boost the morale of teachers and recommended that students' feedback should be presented to teachers scientifically.

Training and Development. Arguably, training has proven to be a motivational program of more considerable significance for employees in most institutions (Dhar, 2015; Noe & Kodwani, 2018). Training and development programs add more weight to the knowledge and experience of employees, which enhances their general performance and levels of productivity in an organization (Nielsen et al., 2017; Noe & Kodwani, 2018; Sila, 2014). Mathis (2006) maintained that an employee or group of workers who want to perform their roles and responsibilities efficiently and effectively need to undergo periodic training to sharpen their skills. The importance of this is that well-trained employees tend to increase the productivity level, which eventually gives huge payoffs to their organizations.

The main focus of training is on making decisions and taking precise actions, steps, and commitments that cause individuals to incorporate newly acquired concepts, knowledge, and skills in their work (Senge, 2014). According to Batram and Gibson (2000), training and career development help organizations to have competent staff who will serve as a replacement in the event of retirement, resignation, or even death of other members. Therefore, equipping employees with adequate training is critical for the perpetual existence of any organization as such professional growth and development serve as a primary motivator for teachers in education and training institutions (Dörnyei & Ushioda, 2013; Durksen, 2017; Leslie, 1989; Lynn, 2002).

2.1.4 Retention

According to the world health organization report, 2006 defines health workers as all people engaged in actions whose primary intent is to enhance health. This meaning extends from WHO's definition of the health system as comprising activities whose primary goal is to improve health. The challenge related to the retention of health workers starts with recruiting students for training and ends with retirement from employment. Wyss writes that the decision to enter the health sector is influenced by the person's cultural, social and economic background, ethnicity, age, gender, education, physical and mental wellbeing, and other circumstances (2004, p. 64). From the literature review, it was found that age, gender, education, and marital status have been found to have a stable relationship with retention and turnover intentions. Several studies in which demographic factors have been employed to investigate job satisfaction and job attitudes have shown that they are strong predictors of turnover intentions (Furnham, Eracleous & Chamorro-Premuzic, 2009; Ng & Sorensen, 2008). A meta-analysis by Borman and Dowling (2008) in their study on teacher attrition and retention, indicated that teachers of 51 years of age or older are nearly 2.5 times more likely to quit teaching than teachers who are 50 or younger.

In terms of sex and retention, it was observed that males are more likely to be retained than females. In a descriptive statistic reported by Luekens et al. (2004) suggests most clearly that retained employees are more likely to be male than female. In a related study, Ingersoll (2001) found males were slightly more likely than females to stay. Aside from age and gender, level of education or qualification is positively associated with turnover, suggesting that the more educated employees are, the more likely they are to quit. With marital status, Crawly (2005), in his study, found that for single officers without children, 58 percent of men and 53 percent of women said they intended to remain in uniform. This concludes that married employees have a higher intention to leave due to family commitment than unmarried employees.

One crucial challenge organizations and corporate leaders face retention because of a shortage of skilled workers, employee turnover and economic growth (Shoaib et al., 2009). Organizations face difficulties attracting and retaining talented and highly experienced staff. According to Mabuza and Proches (2014), the situation has dramatically been affected by urbanization and globalization, which have paved the way for employees' willingness and readiness to change jobs and move to other parts of the world. For this reason, organizations and employers globally are conscious of how to retain skilled employees and are also concerned about the increasing trend of employee turnover. It is an undeniable fact that qualified employees contribute to the success of today's organization. The ability to retain them gives organizations a competitive advantage (Mabuza & Proches, 2014) because relying on skilled and experienced workers will position the organization well in the market (Samuel & Chipunza, 2009).

Employee retention plays a significant role in the overall well-being and success of every organization. Due to this, great organizations cherish dedicated staff and learn how to keep them. Businesses spend a lot of money on recruiting and training people, but still many of them experience a considerable loss of skilled and talented staff. The issue is rapidly becoming problematic for organizations worldwide to recruit, motivate, and keep qualified employees. According to Haider et al. (2015), employee retention refers to the ability of the organization to retain its employees” (p. 57). Due to competition, today’s organizations consider employee retention issues their topmost priority. Many reasons may cause an employee to quit or leave his or her job. Haider (2015) mentioned reasons such as finding a different job, shifting to a different place, getting angry about something and deciding to quit, women getting married, entering motherhood and so on (p. 57).

Employees who quit their jobs also leave with the skills and expertise they have acquired and developed during their tenure with the organization (Mitchell et al., 2001; Haider et al. 2015). Most employees can find new jobs which may be similar to their previous ones or even better. Still, it becomes challenging for the organization to get equally qualified and skilled employees to fill the vacant positions. Owing to this, organizations must understand the significance of employee retention on various grounds. They need to make conscious efforts towards keeping their workers for them not to think of changing jobs or be compelled to quit. Many people still hold on to the conventional assumption that money makes employees stay in an organization. However, there are other compelling factors or reasons that are not related to financial rewards or job-related (Mabuza & Gerwel Proches, 2014; Haider et al., 2015).

All low and middle income countries (LMIC) have health worker labour markets. Some of these countries markets function better than others, and all can be improved. The health worker labour market in a country is made up of two independent economic forces: the supply of health-care workers and the demand for health-care workers. The interplay between the supply of and demand for health workers determines the wages and other forms of compensation paid, such as housing allowance and fringe benefits, the number of health workers employed, and the number of hours they work. These labour market forces also determine the geographic location of health workers and their employment setting (an example of hospitals, clinics). Labour market conditions such as low salaries and a lack of other economic benefits influence employment processes. Still, their influence on the planned allocation of resources is less widely recognized. Thus, an analysis of the labour market is essential to achieve a better understanding of the forces that drive health worker shortage, maldistribution, and suboptimal performance and to develop policies and interventions tailored to different Labour market conditions (WHO, 2016).

Traditionally, analyses of human resources for health have been framed as a supply crisis, with demand-side factors receiving scant attention. The demand for health workers in a country is determined by what the government, private sector, and international actors, such as donors and multinational corporations, are willing to pay to hire them. Willingness to pay is dependent on the level of health-care financing, and the willingness to hire health workers depends on the money available for doing so. Willingness to pay marks a distinction between demand and need. A mismatch commonly exists between the financial resources available – and hence, willingness to pay – for employing health workers and the number of workers needed to cover the health-care needs of the population. The supply of health workers is influenced by the level of remuneration and by many other factors that are economic, social, technological, legal, demographic, and political.

Labour turnover may, however, indicate that the wrong candidate was selected during the recruitment process (Haider et al., 2015). According to Mitchell et al. (2001), organizations today face a massive problem with voluntary turnover. To these authors, changes in family situations, a desire to learn new skill or trade, or unsolicited job offer are personal reasons why employees willingly leave their jobs, whereas observing the unfair treatment of a co-worker, being passed over for promotion, or being asked to do something against one's beliefs are organizational related reasons that influence voluntary turnover (p. 96). Turnover brings enormous costs to both the organization and the individual (Mitchell et al., 2001). At the individual level, the employee may leave the organization because they think it is appropriate to do so at that particular time. However, changing from one job to another requires some personal sacrifice; thus, taking on a new job can be stressful due to the ambiguities and uncertainties surrounding new jobs (Mitchell et al., 2001). In the situation where relocation is involved, the employee, together with their family, needs to adjust and adapt to their new place, an unfamiliar culture, and a new work setting (Kassar et al., 2015; Mitchell et al., 2001). Again,

getting new accommodation, spousal reemployment, and school for the children is all possible obstacles for employees who relocate to new places for new jobs (Kassar et al., 2015; Mitchell et al., 2001). The relocation sometimes brings emotional difficulties, especially when it involves leaving colleagues and other close pals behind (Kassar et al., 2015; Mitchell et al., 2001).

The case is not different at the organizational level. Employees who depart from their organizations carry with them cherished expertise and knowledge acquired through long service, training, and experience (Mitchell et al., 2001; Wilensky, 2015). Employees most times are those who have built excellent relationships with their customers, and as such, their departure inflicts a cost on the organization. Apart from these indirect costs associated with turnover, organizations incur other costs such as exit interview time and administrative requirements, payout of unused vacation time, and cost of temporary workers or overtime for co-workers asked to fill in (Mitchell et al., p. 96- 2001). Besides, organizations also incur replacement costs such as advertising, reviewing of applicants, interviewing and candidate selection as well as formal and informal training costs (Mitchell et al., 2001).

Studies have indicated that employee retention can be seen from two perspectives: job satisfaction and job alternatives (Mitchell et al., 2001). Job satisfaction reflected an excellent treatment in the workplace and is considered an indicator of the emotional wellbeing of an employee (Spector, 1997). In other words, job satisfaction explains employees overall attitude towards their job (Spector, 1997; Wang & Feng, 2003). As an attitudinal variable, job satisfaction is how individuals like or dislike their jobs in fulfilling their physical and psychological needs (Spector, 1997; Wang & Feng, 2003; Montañez-Juan et al., 2019). The focus of job satisfaction is not only from the employee's perspective, but the organization as well since it affects organizational functions. In an organization, job enrichment, competent supervision, pay, well-defined roles, and met expectations cause employee job satisfaction

(Mitchell et al., 2001; Spector, 1997; Wang & Feng, 2003). On the other hand, overloaded roles, ambiguous roles, work-related stress, and repetitive work also cause employee dissatisfaction (Mitchell et al., 2001; Spector, 1997; Wang & Feng, 2003). Therefore, managers and administrators must maintain a conducive work environment to satisfy their employees to retain them (Mitchell et al., 2001; Montañez-Juan et al., 2019).

Job alternative is another perspective of employee retention. As indicated earlier, a favourable work environment and its related factors, such as well-defined roles, promote employee satisfaction and retention (Mitchell et al., 2001; Spector, 1997; Wang & Feng, 2003). Similarly, work overload, role ambiguity is examples of factors that lead to employee dissatisfaction (Mitchell et al., 2001; Spector, 1997; Wang & Feng, 2003). Job dissatisfaction causes employees to look for perceived and actual alternative jobs (Mitchell et al., 2001). In this case, employees who get better job alternatives than their present jobs are likely to leave the organization. Therefore, employee current job characteristics and available work alternatives serve as precursors for voluntary turnover (Mitchell et al., 2001; Wright & Bonett, 2007). Likewise, highly satisfied employees would exhibit a decreased tendency to look around for a new job and decreased inclination to quit the organization (Mitchell et al., 2001; Wright et al., 2007).). Equally, employees with unmet needs generally become dissatisfied and progressively become attracted to alternative jobs, leading to open or discretionary termination and institutional turnover (Mathieu & Zajac 1990; Mitchell et al., 2001; Tziner 2006).

2.2.5 Retention Management

Since employee turnover mostly puts pressure on management's time and workforce planning (Mathew et al., 2012). Organizations have to put proper measures to keep employees for a more extended period. Therefore, managing retention in an organization calls for ongoing identification of the causes and nature of turnover, calculated ways of dealing with the impact

of retention on institutional success, and the establishment of organized and suitable retention incentives (Allen et al., 2010; Mathew et al., 2012). Employee retention, according to Mathew et al. (2012), is a step taken by organizations and managers to encourage their employees to remain working with them for a considerable number of years. As indicated earlier, the benefits that come with employee retention favours both the organization and the employee. However, today's employees are somewhat different in the sense that little dissatisfaction makes them think of leaving their organizations to another (Mathew et al., 2012; James & Mathew, 2012). It therefore rests on employers to keep their key staff members in order not to lose the star workers among them (Gurumani, 2010).

Retention management is an essential source of competitive advantage in today's business world (Vaiman, 2008). Thus, organizations that manage employee retention issues well are likely to survive their competitors (Singh & Rokade, 2014). A study conducted by Whitt (2006) revealed that organizations could reduce employee turnover when they increase retention. Besides, Cappelli (2000) suggested that managers and employers must replace their original notion about the goal of human resource management, which is to reduce employee turnover to the new or recent HR goal, which seeks to affect who leaves the organization and when. Series of research conducted by many scholars have identified different practices of retention (Agarwal & Ferratt, 2002; Coetzee & Stoltz, 2015; Deery & Jago, 2015). Namely, opportunities for career training and development, added financial incentives, periodic performance appraisal are some of the notable retention practices.

2.2.6 Retention Factors for Employees

Paying much attention to factors that affect employee retention promotes organizational growth and success (Agrela et al., 2008). Research indicates that retention policies or approaches which successfully meet the needs of each one of the employees eventually increase the ability

for organizations to adequately adjust to the change processes in the organization (Sinha & Sinha, 2012). Again, studies have shown that present-day retention strategies cover more than the regular salary, incentive package, and compensation to include employee motivation as a vital element to cater for extended stay and diversity of the individuals in the organization (Feldman, 2000; Sinha & Sinha, 2012; Thomas, 2000). As such, retention factors comprising employees needs and aspirations increase the individual's level of job satisfaction, commitment, and loyalty (Boomer Authority, 2009). Below are some factors that enable organizations to retain their employees.

Skills recognition. According to Yazinski (2009), identifying and valuing employees experience and achievements is an effective strategy to enhance retention in the organization. Research has indicated that individuals become fulfilled when their work accomplishments are acknowledged by their superiors (Redington, 2007). This recognition, when accorded the individuals, will go a long way to prolong their stay with the organization (Redington, 2007; Yazinski, 2009). A study conducted by Yazinski (2009) showed an increasing trend in the number of job-seekers looking out for corporations that encourage and inspire employee suggestions, growth, input, teamwork, and education, beyond the regular salary, benefit, and incentives provided by employers. The advantages the organization derives from employee recognition is priceless, still studies buttress that verbal praise alone can promote organizational loyalty, positive behaviour, motivation, confidence, teamwork, ethics and employee growth (Redington, 2007). Therefore, skill recognition and career growth opportunities promote employee effectiveness, performance, and retention (Agrela et al., 2008; Redington, 2007).

Learning and working climate. Learning and opportunities for career development are crucial factors for retaining skilled or gifted employees (Arnold, 2005; Walker, 2001). Therefore, it appears vital for organizations to create a conducive learning and working environment for all employees. The idea of learning and working climate can generally be referred to as the context

in which employees acquire new knowledge and skills while performing their regular duties (Abrams et al., 2008). In a narrower sense, learning and working climate is guidance and appreciation at work; the pressure of work; the amount of empowerment and the responsibility that employees experience; choice in job tasks and development; provision of challenging and meaningful work; and advancement and development opportunities (Sinha & Sinha, p. 148-2012). Studies have shown that an appreciative approach, friendly working and learning environment, and operational thought have positive impacts on employee retention (Abrams et al., 2008; Sinha & Sinha, 2012; Verheijen & Dewulf, 2004).

Job flexibility. Most employees enjoy the right life/work balance in their organizations. The regular nine-to-five working plan does not favour them all the time since they may need time to attend to their outside needs and interests. For this reason, employers who provide such requirements for their workers may retain them for more extended periods (Boomer Authority, 2009). Scholars report the significance of job flexibility, categorically different schedules that better accommodate employee work hours, responsibilities, workloads, and placements near family responsibilities (Cunningham, 2002; Maume, 2016; Pleffer, 2007). Research has indicated that flexibility permits people to establish a delicate balance between personal responsibilities and work, something that is of interest to all categories of employees (Eyster, 2008; Galea et al., 2015). Again, it has been established that individuals who enjoy job flexibility options at the workplace increase their commitment, satisfaction, concentration, loyalty, and productivity (Prenda & Stahl, 2001).

Superior-Subordinate Relationship. Employees always need the support of their superior to push their developmental programs. Thus, without the right culture supporting them, employees career programs may not yield any result. According to Zenger et al. (2000), any program designed to produce a desired or intended result needs strong backing from leaders in high management positions. These leaders become active role models for followers. Mostly,

supervisors and managers assume a new role anytime they embark on employee development programs (Sinha & Sinha, 2012). They take on the coaching roles to assist individuals in directing their careers and helping their development agenda (Sinha & Sinha, 2012). At this point, managers prepare themselves through workshops to acquire skills that will help them to supervise and work with employees undergoing career training (O'Herron & Simonsen, 1995). Employee coaching is significant in assisting them in realizing their career goals and objectives, yet it also informs the employees how the managers care about their development. Employee coaching is good enough to make a significant difference in workers motivation and retention (Moses, 2000).

Employee motivation. Traditionally, management practice and theory has significantly emphasized on extrinsic motivators (Sinha & Sinha, 2012). However, intrinsic rewards remain powerful motivators necessary for today's work environment (Osabiya, 2015; Thomas, 2000). Motivational issues in our days have become complicated due to the opportunity and wealth most workers have enjoyed. Research indicates that individuals require intrinsic rewards to be inspired and to give out their best performance (Osabiya, 2015; Thomas, 2000). Today, skilled workers have several alternatives than before, and they may leave if they are not pleased with their job content or employer (Osabiya, 2015). Since unrewarding jobs compel employees to leave, most organizations are considerably losing their skilled workers (Osabiya, 2015; Thomas, 2000). Organizations are required to improve upon their intrinsic reward process by ensuring that employees get energized and fulfilled. When organizations can do this, the workers themselves would not want to leave. Hence, they will be retained due to the meaningfulness of their work (Sinha & Sinha, 2012).

2.2.7 Equity

The success of the Human Resource Department of any organization depends on its ability to institute policies regarding job design, reward systems, motivation, and equity (Armstrong & Taylor, 2020). Reward systems, job design, and motivations are designed to enhance employees' workplace productivity. Equity in the workplace is essential to ensure that workers' input matches with the wages they receive for their efforts (Budd & Colvin, 2008). Many organizations and institutions have felt the significant need for equity in the workplace, and as such human resource departments must find ways to reduce discrimination to improve productivity (Kunze et al., 2011; Torrington et al., 2002). Human resource management ensures the employment of the right people to occupy positions that are suitable for their abilities. They see to it that employees are productive (Torrington et al., 2005). They are to promote equity in every part of an organization that can increase productivity (Okun, 2015).

Individuals in an organization differ in gender, race, culture, ethnicity, sexual orientation, personality, marital status, religion, age, social status, and disability (Shih et al., 2013). Today, organizations have become fully aware of the importance of recruiting people from different backgrounds to enrich their workforce. Organizations stand to reap from the varying skills, talents, experience, and abilities the employees bring to the organization (Helm Stevens & Ogunji, 2010; Scott et al., 2011). Thus, many institutions hire people from different backgrounds to intensify their competitive advantage (Helm & Ogunji, 2010). Again, organizations increase productivity, creativity, and flexibility when they employ people from different backgrounds (Saxena, 2014; Scott et al., 2011). In doing so, enable organizations to attract more workforce and maintain superior marketing capabilities or space (Harvey & Allard, 2012; Morgan, 2014).

According to Braveman and Gruskin (2003), Equity means social justice or fairness; it is an ethical concept, grounded in principles of distributive justice (p. 254). Thus, the concept of

equity is derived from standards or norms, and it is essentially based on values (Braveman & Gruskin, 2003). Apart from being an ethical principle, equity is consistent with and closely connected to human rights principles (Braveman & Gruskin, 2003). To Budd and Colvin (2008), equity entails fairness in both the distribution of economic rewards and the administration of employment policies (p. 462). In employment relationships, Equity is a set of fair employment standards that respect human dignity, the sanctity of human life and liberty, and cover both material outcomes and personal treatment (Budd, p. 7- 2012). In this research, distributive justice is very important for health workers, when health tutors compare what is allocated to them compared to their colleges in the same institution or different institution and if their colleague's allocation is greater than them although they perform the same task, the same qualification, and experience that could serve as a de-motivation because they feel there is no distributive justice. A typical example of distributive justice is promotions. When tutors in the cities enjoy social amenities and are promoted while their colleagues in the rural area remain at the same level could serve as a demotivation factor because the promotion was not allocated fairly. This renders the focus of this study - the relationship between health tutors' retention and level of motivation - potentially very relevant to analysis in terms of equity theory. Equity in the workplace intends to convey or indicate a fair treatment for everyone (Braveman & Gruskin, 2003; Budd, 2004; Budd & Colvin, 2008). The existence of equity at workplaces ensures that employees enjoy equal access to opportunities (Budd & Colvin, 2008; Hardt, 2016). It also creates a working atmosphere advantageous for both the employer and the employee (Budd, 2004; Hardt et al., 2016). Sen (1992) asserted that equity in the workplace is defined across different dimensions. As such, the principal matter in assessing or evaluating equity is how equity is interpreted or explained. According to the author, aspects such as capability, rights, treatment of equals, opportunities, justice, primary good, income, resources, utility, wealth, and welfare are used to define equity (Sen, 1992).

Equity in the workplace and the opportunities provided by an equitable organization drive individuals to achieve (Dugguh & Dennis, 2014; Kundu & Mor, 2017). Thus, when employees realize that their efforts are given appropriate acknowledgment and that rewards will match or agree almost exactly with their efforts, they are motivated to give out their best to achieve their target (Dugguh & Dennis, 2014; Wiley & Kowske, 2011). This tendency is clearly described in more detail by equity theory, which connects employee effort to fairness (Adams, 1963; Bowman, 2016). In a situation whereby the employee is given bonuses, promotions, and rewards at a job that somewhat recognizes merit, the organization ends up having the right calibre of employees, doing the right jobs, at the right positions and time (Dugguh & Dennis, 2014; Wong et al., 2017). Therefore, equity and fairness in the workplace lay the platform for a dynamic and positive culture of achievement (Shannon, 2018; Wong et al., 2017).

Again, equity in the workplace promotes employee retention (Buttner & Lowe, 2017; Sitati et al., 2016). Thus, employees who are sure of a brighter future with their organizations would prefer to stay and enjoy it. Also, employees with high morale with what they do in the organization become happy to the extent that they may not want to quit their job. Conversely, employers who retain their workers tend to relieve themselves of brain drain, cost of recruiting new staff, and their training expenses (Buttner & Lowe, 2017; Eftimov & Ristovska, 2019). On the contrary, the absence of workplace equity costs employers because employees will not have any feeling to be committed and loyal when they experience unfair treatments at their workplace (Eftimov & Ristovska, 2019). Keeping employees for a more extended period is a significant investment for the employer since he will own skilled, experienced, and star workers to meet current and future competitions (Eftimov & Ristovska, 2019). An organization with an excellent record of equitable conduct towards its employees appeals to many potential employees who would want to enjoy a better and quality work life. Therefore, equity is one of the reasons why employees join an organization.

Workplace equity also serves as a starting point for meritocracy, ensuring that employees bonuses, rewards, and promotions are attained through merit, but not through favouritism and special treatment (Castilla, 2016; Turk, 2016). For this reason, most successful organizations have established formal structures to see to it that employees and job applicants are judged based on their abilities, efforts, skills, and performance, without giving attention to race, sexual orientation, gender, national origin, or status (Castilla, 2016). Meritocracy, when practiced well in an organization, builds a win-win situation for both the employer and employees (Castilla, 2016; Holck & Muhr, 2017). Thus, the culture of meritocracy in an organization drives employees to achieve a high or specified level of success, which enables them to discover their rightful place in the organization (Castilla, 2016; Holck & Muhr, 2017). Similarly, employers and managers also end up having an organization staffed for higher achievement and productivity (Castilla, 2016; Holck & Muhr, 2017).

Meanwhile, organizations that give chase to workplace equity and promote meritocracy easily attract more talents than those that do not, and always try not to violate employment laws (Castilla, 2016; Frank, 2016). Employees who are skilled and talented would still want to be recognized, treated, and compensated impartially without thinking about those personal issues that give rise to preferential treatment for a selected few employees (Castilla, 2016; Schermerhorn Jr & Bachrach, 2017). In the same vein, employees who are talented, skilled, and ready to shine become happy and motivated to work for organizations with higher regard for equity and fairness (Schermerhorn Jr & Bachrach, 2017). As a result, the organization benefits from their energy, ability, and dedication, while the employees also get the opportunity to work with other skilled, talented, and great achievers (Blanchard, 2018).

Equity in the workplace also broadens diversity (Forknell, 2017; Roberson, 2019; Wittenberg-Cox, 2016). Diversity has been used to address the needs and the new trends of the business environment. As such, researchers have given attention to the study of diversity in

organizations, including its conceptualizations, measures, effects, and contexts (Roberson, p. 70- 2019). Diversity in the workplace allows employers and managers to have in their possession more experience, more source material, and more perspective to rely on in making decisions, solving problems, and producing innovative services and products (Bardach & Patashnik, 2019; Roberson, 2009). That is to say, through diversity, the organization's intellectual capital deepens and widens. Therefore, organizations with a tradition to hold employees and attract top talent become competitive and favourable in achieving its overall goals and objectives (Argenti, 2018; Blanchard, 2018; Forknell, 2017; Roberson, 2019).

Promoting Equity in the workplace. To promote equity in the workplace, employers must first adopt a more comprehensive approach to their appointment and recruitment practices (Forknell, 2017). Forknell enumerated possible ways employers can modernize their hiring and recruitment practices to do away with prejudice and inspire their workforce for success. Forknell stated that the employer needs to recognize the area where he is recruiting his employees, the exact needs of the people in the area, and how the employee base thinks about their community. Doing these is very important because it will enable the employer to match the needs of the consumer, and again make employees comfortable in their new work environment. By establishing a considerably diverse workforce that mirrors the community in which they work, employers can employ people from different backgrounds, which as a result, will stimulate equality among each and everyone in the organization as well as those outside the organization (Forknell, 2017; McCuiston & Wooldridge, 2004).

Again, employers can promote equity in the workplace by reviving the employee appraisal procedure (Forknell, 2017). Typically, recruiting employees is not as difficult as retaining them. Therefore, employers need to freshen up their employee assessment and appraisal process and use current and modern tools to weigh employee success and productivity (Forknell, 2017). According to Forknell (2017), organizations that still use old-fashioned tools

to evaluate their employees usually depend on the direct supervisor or manager to assess the accomplishments of the employee, and that can lead to unconscious bias against the individual. Employers must establish a structure to ensure checks and balances when evaluating employees, allow senior managers to be actively involved in the entire process, or use adequate information to score every team member (Forknell, 2017; Milost, 2007). In a situation where reprimand or evaluation has to do with behavioural issues, it is always proper to present the feedback fairly and honestly to avoid the possible occurrence of unintended discrimination (Forknell, 2017).

Similarly, employers who want to promote equity in the workplace must learn to be more flexible with employees' work hours (Golden, 2001). Giving your employees "an ability to alter their starting and ending times of work" can play a role in their retention and productivity level (Golden, 2001, p. 1157). However, balancing work and life has caused continual trouble and distress in the workplace (Forknell, 2017). While some younger staff complain of working more hours than their older counterparts, many women face unfair judgment at the workplace for maternity leave and the time they take off to attend to their sick children (Forknell, 2017; Hall, 1990). The complaint that women with children work fewer hours results in disagreement between singles and workers who do not have children. As a result, many employees feel unequal to their co-workers in the workplace. It is, therefore, essential for employers to remain in the middle when it comes to the work/life balance of employees. However, employers are cautioned against being too equal among all workers since that can alienate them and decrease productivity (Forknell, 2017).

Another way through which employers and managers can promote equity is by building an equal opportunity policy in the workplace (Darling-Hammond, 2012; Forknell, 2017). Thus, it is a good plan for managers to examine their current office practices and create new policies that promote equal opportunity in their workplace (Forknell, 2017). By equal opportunity, we

mean giving similar or identical treatment to employees and not deprived or underprivileged by bias and prejudices (Anderson, 2007; Quillian, 2006). That is to say, the best candidate for a promotion or a job is the one who secures it based on experience, qualifications, and knowledge. Therefore, diversity in the workplace values respects every employee's differences (Barak, 2016; Kundu & Mor, 2017). Employers must create policies that will eliminate the risk of unconscious discrimination and partiality in employee appraisal and evaluation, give every employee some level of flexibility by recompense hardworking staff, and allowing them some extra time to attend to family demands (Darling-Hammond, 2012; Forknell, 2017; Kundu & Mor, 2017). It is important to note that promoting equity is a continual balancing act which requires employers and managers to diversify their workplace and ensure that every individual, irrespective of gender, race, or sex, receive fair treatment and feel like an equal.

2.3 Theoretical Review

The theoretical literature review help establish what theories already exist, the relationships between them, to what degree the existing theories have been investigated, and to develop new hypotheses to be tested.

2.3.1 The two-factor theory of Herzberg

About the Theorists. Frederick Herzberg was an American Phycologist who took adaptation from Maslow's theory of need and developed the two-factor theory in 1959 (Alshmemri et al., 2017; Ghanbahadur, 2014). Herzberg two factor theory is a motivational theory which is also known as motivation-hygiene theory. The position of the theory is that there are a variety of factors that determines job satisfaction. These factors give meaning to the work of employees (Herzberg, 1971).

The two-factor theory of Herzberg consists of hygiene factors and motivators. Herzberg identified hygiene factors like pay and benefits, workplace conditions, and job security (Ghanbahadur, 2014). Further, he mentioned human resource elements such as talent recognition, challenging work, employee participation in decision making, increase responsivity, the feeling of the importance of employees, growth, and achievement as part of the hygiene factors (Herzberg, 2017; Pardee, 1990; Pugh, 2017). According to Herzberg, hygiene factors on their own do not motivate or satisfy employees. However, employees are dissatisfied when these hygiene factors are not present in the workplace (Alshmemri et al., 2017; Ghanbahadur, 2014).

The above position of the theory implies that the combination of motivators and hygiene factors leads to employee satisfaction and motivation in the workplace (Herzberg, 2017; Pardee, 1990; Pugh, 2017). When the employer or management compromises either motivators or hygiene factors, employee dissatisfaction grows, and motivation diminishes in the organization (Alshmemri et al., 2017; Ghanbahadur, 2014). Therefore, leaders of the organization should ensure hygiene factors in their organization to eliminate job dissatisfaction among employees (Alshmemri et al., 2017; Ghanbahadur, 2014).

According to Herzberg (2017), employers measure, control, and manipulate hygienic factors in an organization than motivational factors. The motivational factors are very elusive, complex, and subjective to measure (Alshmemri et al., 2017; Ghanbahadur, 2014). However, when managers over concentrate on hygiene factors and neglect motivational factors, employees will seek more hygiene factors, which will harm the development of motivated employees (Herzberg, 2017; Pardee, 1990; Pugh, 2017).

The first step of applying Herzberg two factor theory is proper management of the hygiene factors (DeShields et al., 2005; Fareed & Jan 2016; Pardee, 1990). There are five processes involved in managing hygiene factors to enhance the application of the Herzberg two factor

theory. The procedures include identification of the type of hygiene, allow the hygienic factor to play a hygiene role in the organization, provision of hygiene factors for the organization including those that hurt management, keeping hygiene administration simple, and give up on hygienic factor when necessary (DeShields et al., 2005; Fareed & Jan 2016; Pardee, 1990).

2.3.2 Context of the Two-factor Theory

Frederick Herzberg modified Maslow's Hierarchy of needs and came out with job enrichment motivation-hygiene theory (Alshmemri et al., 2017; Ghanbahadur, 2014). Herzberg developed the two-factor theory by studying accountants and engineers with a total research participant of 203 with a semi-structured interview as the data collection tool (Ghanbahadur, 2014). The findings of the study made him bifurcate two factors, hygiene factors, and motivators.

The hygiene factors include but are not limited to the following: job security, friends in the workplace, and basic pay (Alshmemri et al., 2017; Ghanbahadur, 2014). The motivators also consist of the following: achievement, challenging work, and recognition. According to Herzberg (1987), the totality of these factors is critical issues that ensure employee satisfaction in the workplace.

The theory explains that hygiene factors are not motivators. However, the lack of hygiene factors leads to employee discontentment (Herzberg, 1959). Further, Herzberg argued that motivators could not also be validated as the only factors that ensure job satisfaction in the workplace (Herzberg, 2017; Pardee, 1990; Pugh, 2017). The fundamental principle underlying this theory is that employee satisfaction depends on both factors in the workplace. Herzberg used critical incident techniques in his research for the interview and data collection (Herzberg, 2017; Pardee, 1990; Pugh, 2017). The significant incident interview relies on the respondent's memory to form the data for the research (Pardee, 1990). This approach used by Herzberg has attracted some criticism that will be discussed later in this section. The theory indicates that

intrinsic motivational factors do not lead to employee job satisfaction when the extrinsic motivational factors in the workplace are deficient (Pardee, 1990; Pugh, 2017).

2.3.3 Development of the Two-factor Theory

Herzberg's two-factor theory of motivation is not new; it dates back to 1959 as the outgrowth of a research study project on job attitudes conducted by Herzberg, Mausner, and Snyderman (Noell, 1976). Herzberg elaborated on the concept that man has two sets of needs: the need to avoid pain and grow psychologically (Noell, 1976). Herzberg posited that a critical study of the nature of human beings suggests that there exists a human being who is impelled to determine, discover, achieve, actualize, progress, and to his or her existence (Noell, 1976). According to Herzberg (1959), these needs summarize Maslow's concept of man.

According to Herzberg, a basic understanding of the concept that man exists as a duality and has two sets of needs present at the same time is germane for the development of the two-factor theory (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017). Another essential aspect of man's dual nature that laid the foundation for the two-factor theory is that human beings' needs are mostly independent of each other (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017). Thus, the two concepts of man consist of a system of needs operating in opposing directions (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017). Furthermore, meeting the needs of one facet of man has little to do with or no effect on the needs of the other aspect in man (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017).

Herzberg and his colleagues researched in 1959 to test the concept that man has two sets of needs (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017). The research engaged about 200 accountants and engineers (Noell, 1976). Analyses of the responses led to Herzberg and his colleagues conclude that job satisfaction consisted of two separate independent dimensions (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017). The first dimension is related to job

satisfaction and the second dimension to job dissatisfaction. Based on the above discovery, Herzberg developed the two-factor theory, which explains that motivator and hygiene factors combine to give job satisfaction to the employee (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017).

2.3.4 Construct of the Two-factor Theory

Herzberg's two-factor theory examines job satisfaction by exploring the duration and frequency of two significant constructs; motivation and hygiene factors. Both principles tend to affect employee satisfaction and organizational performance (Herzberg et al., 1959).

Hygiene factors. According to Herzberg (1974), things that make people unhappy in organizations has nothing to do with what they do but rather how poorly they are treated. These treatment factors are not related to work content, but the job content. Therefore, people who are dissatisfied with their jobs become unproductive, unhappy, less valuable, and feel like quitting their jobs. Hence, the absence of hygiene factors brings about job dissatisfaction, which is associated with negative employee behaviour that affects performance and output (Hrzberg et al., 1959). The main factors in this construct include company policy, supervision, working conditions, administrative practice, interpersonal relationships, salary, security, and status (Herzberg, 1974).

Herzberg (2017) posited that the hygiene factors are not motivational. When hygiene factors are used to achieve a conducive work environment, the hygiene factors hurt the work environment in the long run (Herzberg, 2017; Pardee, 1990; Pugh, 2017). Hygiene factors enhance employee connection to colleagues and job. However, the hygiene factors help the employee to accommodate the adverse working conditions for a while, but eventually, the employee will be dissatisfied if the right motivational factors are still absent in the workplace (Herzberg, 2017; Pardee, 1990; Pugh, 2017).

According to Herzberg (2017), employers measure, control, and manipulate hygiene factors in an organization than motivational factors. The motivational factors are very elusive, complex, and subjective to measure. However, when managers over concentrate on hygiene factors and neglect motivational factors, employees will seek more hygiene factors, which will hurt the development of motivated employees (Herzberg, 2017; Pardee, 1990; Pugh, 2017).

Herzberg asserted that the first step of applying the theory is by properly managing the hygiene factors in the workplace (DeShields et al., 2005; Fareed & Jan 2016; Pardee, 1990). There are five processes involved in managing hygiene factors in an organization. The processes are the identification of the type of hygiene; allowing the hygiene factor to play the role the hygiene factors are supposed to play in the workplace; providing hygiene factors in the workplace including the factors that hurt management; keeping the administration of hygiene factors simple; finally giving up on hygiene factor in the workplace when necessary (DeShields et al., 2005; Fareed & Jan 2016; Pardee, 1990).

Herzberg (2017) continued that when employers deprive employee hygiene factors in the workplace, it leads to job dissatisfaction; however, improving hygiene factors does not lead to job satisfaction. Hersey and Blanchard (1982) explain that the provision of hygiene factors in the workplace eliminates job restrictions and job dissatisfaction. Still, the hygiene factor does a little in motivating employees to perform at their highest capabilities. To provide hygiene factors in the workplace, employers must understand the three psychological states of employees (Pardee, 1990). First, employees are affected by the meaningfulness of their work (Herzberg, 2017; Pardee, 1990). Secondly, employees are affected by the outcome of their work, and finally, employees their performance feedback (Herzberg, 2017; Pardee, 1990).

Another principle that interplays with hygiene factors are the 'she principle'. She principle involves an escalation of hygiene phenomenon in the workplace (Hur, 2018; Pardee, 1990). According to Hur (2018), the *she principle* is also known as the rising expectation of workers.

Impliedly the want of workers increases as they receive more from their employer (Hur, 2018). Herzberg called this escalating phenomenon as *zero points*. According to Mathis et al. (2008), hygiene factors should be the basis of consideration to avoid the *she principle*. When employers provide hygiene factors in the workplace, they will be motivated to work hard and remain in the job.

Motivators. The next major component of the two-factor theory is the motivator. Herzberg (2017) noted that intrinsic motivation is the primary factor that leads to job satisfaction. Intrinsic motivational factors include interpersonal relationships, supervision, working conditions, company policy, salary, and administration (Caston & Braoto, 1985; Hur, 2018). Though intrinsic factor leads to job satisfaction, the absent of extrinsic factors leads to deficient motivational factors in the workplace.

Motivators are also referred to as satisfier, because ‘if they are present in its appropriate measure in the workplace, they bring about work motivation as a corollary to their creating positive attitudes of job satisfaction’ (Herzberg, 1974, p. 18). According to Herzberg et al. (1959), good performance exhibited by people or employees in an organization can be attributed to job content factors (motivators or satisfiers). These are intrinsic factors that can be satisfied psychologically to produce good attitudes toward work. Therefore, employees who are satisfied become much more productive and industrious. Examples of motivation factors (satisfiers) are achievement, recognition, work itself, responsibility, advancement, and growth (Herzberg et al., 1959; Herzberg, 1982, 1971)

The findings of Herzberg and his associates revealed that specific attributes of work are invariably related to job satisfaction and are integral to the job (Hoy & Amp; Miskel, 2013; Herzberg, 1968). These factors comprise achievement, recognition, work itself, responsibility, advancement, and growth (Herzberg, 1968; Hoy & Miskel, 2013). The motivation factors generate job satisfaction with the potential to meet the individual need for self-actualization

and psychological growth (Hoy & Miskel, 2013). Motivation is the driving force behind the actions of an individual to achieve a particular goal (Ozsoy et al., 2019). The theory makes it clear that job satisfaction and job dissatisfaction are two separate phenomena and that the absence of motivation factors will result in decreased motivation and vice versa (Herzberg, 1968; Hoy & Miskel, 2013; Ozsoy et al., 2019).

Herzberg (1968) posited that the reason why people will associate a lack of motivation to job dissatisfaction is a result of some myths about motivation. For instance, the assertion that reducing the working hours for employees will motivate them, but it turned out that people become less motivated when they stay away from their jobs for too long (Herzberg, 1968). According to Caston and Braoto (1985), motivators make employees committed to their job. Aldag and Brief (1979) attributed job behaviour to the motivation of the employee as well as the employee involvement with other people in the workplace.

2.3.5 Strength and Weaknesses of theory

Strength. The theory is widely accepted as a theoretical framework for studies on employee motivation. Researchers validate the use of Herzberg two factor theory for studies on motivation because the theory emphasizes motivation emanating from employees instead of motivation emanating from external factors (Herzberg, 2017; Pardee, 1990; Pugh, 2017). Hence, the application of the theory helps researchers to explain why organizations must ensure improvement in the working environment and conditions of service so that employees will feel motivated in the workplace (Herzberg, 2017; 1976; Pardee, 1990; Pugh, 2017).

The two-factor theory, through research, explains the notion that many organizations hold that employees get job satisfaction from salary (Herzberg, 2017; Pardee, 1990; Pugh, 2017). However, the two-factor theory gives a comprehensive list of motivators and hygiene factors that organizations use to solve employee problems (Herzberg, 2017; Pardee, 1990; Pugh,

2017). The theory helps to address issues such as job dissatisfaction, employee demotivation, and labour turnover by making sure that factors that dissatisfy employees can be reduced through creating a conducive and employee-friendly work environment (Herzberg, 2017; Pardee, 1990; Pugh, 2017).

The strength of the theory also lies in how the theory treats money in explaining motivational issues of employees. The theory emphasizes that money is a secondary issue because employees are motivated by things such as recognition, job promotion, and interpersonal relationship with other workers (Herzberg, 2017; Pardee, 1990; Pugh, 2017). These are the factors employees consider as motivational than money based on the explanation of satisfiers and dissatisfiers in the workplace by the theory (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017). Thus, Herzberg's theory brings a change of measuring employee satisfaction through motivator and hygiene factors in the workplace and not money (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017).

Weaknesses. The significant portion of the controversy between supporters and critics of the theory stems from the lack of an explicit theory (King, 1970). Ondrack (1974) addressed the facet of the controversy concerning the theory. Ondrack conducted a test on the theory using an instrument adapted from the occupational value scale. The occupational value scale was a semi-structured scaled used to collect data concerning the validity of the two-factor theory. The responses from the instrument were classifiable using the familiar Herzberg job-factor categories.

Interestingly the results from the test did not conform to the Herzberg two-factor pattern. Herzberg's six motivators in order of arrangement are Achievement, recognition, work itself, responsibility, advancement, and growth. However, the results from the Ondrack (1974) study indicates that the participant arranged the six most essential motivators as follows: work itself, salary, relations with peers, achievement, independence, and responsibility (Herzberg, 2017;

Noell, 1976; Pardee, 1990; Pugh, 2017). There are two factors on the respondents' lists: hygiene factors and not motivators (salary, relations with peers). In the Herzberg model, the independence of an employee is a new factor developed by the study. Regarding the sources of dissatisfaction, Herzberg's theory identified company policy and administration, but these factors were barely mentioned by the research participant (Herzberg, 2017; Noell, 1976; Pardee, 1990; Pugh, 2017).

According to Smerek and Peterson (2007), the only motivator factor acting in conformity with Herzberg's theory was 'work itself.' Dunaway (2009) find Smerek and Peterson's (2007) assertion cohesive and point out that the same factor was the only motivational factor that impacted job satisfaction. Although Dunaway (2009) conducted his research on nurses and Smerek and Peterson (2007) on large public research universities, both studies raise questions about Herzberg's theory after careful examination of available literature.

Alignment. Research has indicated that motivation and job satisfaction is critical in the workplace (Ozsoy et al., 2019). Herzberg's theory has been used over the years by administrators and managers to determine the actual tools used as incentives for employees at the workplace (Prasad et al.; Karumuri, 2018). The existence of motivators or satisfiers will help the researcher to explain the motivational need of the tutors in public health training institutions (Ozsoy et al., 2019).

One of the satisfiers is job responsibility. The idea of employees being given some ownership of the work done provides job satisfaction (Kotni & Karumuri, 2018). These additional responsibilities required employees to work late after regular working hours. The other job responsibility encourages employees to work hard because they expect that their effort will be recognized by management.

Again, the achievement is another motivator of Herzberg two factor theory. The idea of employees getting a sense of accomplishment in the organization and getting recognition for

their performance is a good motivation factor (Akdemir & Arslan, 2013; Kotni & Karumuri, 2018). This implies that the theory is appropriate to explain the motivational needs of the tutors in a rural public health training institution and its implication of tutor rural-urban migration. Similarly, growth and advancement opportunities are essential motivators for employees. These opportunities, when taken away, results in a lack of motivation at the workplace (Hoy & Miskel, 2013; Ozsoy et al., 2019). Impliedly, employees expect that their promotions should be given much attention. If not, they may be dissatisfied with the job. Overdue promotion naturally demoralized employee and cause them to migrate to other places where management gives notice to the opportunity to grow on the job. The lack of opportunity for growth and advancement in the workplace could lead to a lack of motivation (Hur, 2018; Hoy & Miskel, 2013) and the loss of valuable employees.

Additionally, hygiene factors such as company policy, supervision, working conditions, interpersonal relationships at work, salary, benefits, and job security can lead to dissatisfaction (Hoy & Miskel, 2013; Hur, 2018). For instance, the remuneration and salary structure should be suitable and fair to all employees (Akdemir & Arslan, 2013), especially in the same domain. The theory applies to the study because it provides the framework to explain why employees will migrate because of unequal salary structure in the same institution.

Again, company policies and administrative policies should be applied fairly and equally to all employees (Akdemir & Arslan, 2013). Apart from the policies being implemented fairly, they must be clearly stated to avoid ambiguities (Akdemir & Arslan, 2013; Ozsoy et al., 2019). In this case study, the application of policies of public health training instructions in Ghana is essential to create a fair working environment for tutors in the rural areas. In other words, the theory helps the management of institutions to apply policies of an organization reasonably in all the geographical location of the organization.

Herzberg's theory suggests that the attributes that lead to job satisfaction are distinct from those attributes that lead to job dissatisfaction (Herzberg, 1968). Therefore, Herzberg and his associates believed that an organization set out to eliminate dissatisfying job factors; they must create some tranquillity at the workplace but not to automatically strengthen job performance (Herzberg, 1968). The implication is that managers should guarantee the hygiene factors to avoid work dissatisfaction while ensuring that the work environment is enthusiastic enough to motivate employees to work hard to achieve set goals (Ozsoy et al., 2019)

2.3.6 Application of Two-factor Theory to the study

There have been various studies that support and validate the application of Herzberg's two-factor theory for research on employee motivation and retention. Chien (2013) tested the validity of Herzberg's two-factor theory and found it to be plausible to study motivation and retention among employees. Kwasi and Amoako (2008) justified applying the theory to conducting a study on Ghanaian workers in particular and Africa. Kwasi and Amoako (2008) explained the use of Herzberg's theory in Ghana through exploratory literature. According to Kwasi and Amaoko (2008), hygiene and motivation factors are relevant in general employment conditions in African in General.

Elding et al. (2011), in a study on motivation of staff in four private business organizations in the UK, showed how similarities between variables under Herzberg two factor theory could be used to produce a practical model of motivation for use in employee motivation and performance. Elding et al. (2011) study correctly validated Herzberg's theory for research on employee motivation in the public sector. Wesley et al. (2012) justified the theory for mixed methods in his review of worker motivation in Lincoln Manufacturing Company, Nebraska. The quantitative part relied on the survey data designed using Herzberg's two-factor theory as a basis. He used a triangulated analysis where data from multiple sources were compared and

cross-checked with data collected from people with different perspectives or follow-up interviews with the same people.

Other studies have also focused on the validation of Herzberg's theory for research. Within Africa, there have been numerous applications of Herzberg Theory in the study of motivation in Africa. For example, Ehiorobo (2017) conducted a study in Nigeria on the implication of adequate motivation on workers' productivity in a power generating company. Ehiorobo (2017) juggled among most theories of motivation, including Herzberg's, and recommended the two-factor theory is applicable for studies concerning employee motivation and retention. Meanwhile, Marnewick (2011) in South Africa investigated the applicability of Herzberg's two-factor theory to Africa 50 years after the theory's existence. Marnewick's research concluded that information technology employees were indeed motivated by achievement, recognition, responsibility.

Lwanga-Ntale et al. (2008). used Herzberg's two-factor theory to understand the performance of Sebagala and Sons, a private supplier of electric equipment in Uganda. Lukwago et al. (2014). validated Herzberg's two-factor theory in their study on motivation of the health sector in Uganda. The study found out that half of the doctors in Uganda dissatisfied and would consider leaving the health sector or the country.

Herzberg's theory is valid and is widely accepted because of its theoretical and practiced simplicity and has been endorsed by most researchers (Idris & Wan, 2012; Malik & Naeem, 2012). The studies referred to and other studies worldwide demonstrate that education based on Herzberg's theory is inconclusive. However, the theory provides a satisfactory framework for studying motivation. Despite the criticisms of Herzberg's two-factor theory, researchers widely accept the theory because of the simple nature of the theory's theoretical practice (Idris & Wan, 2012; Malik & Naeem, 2012).

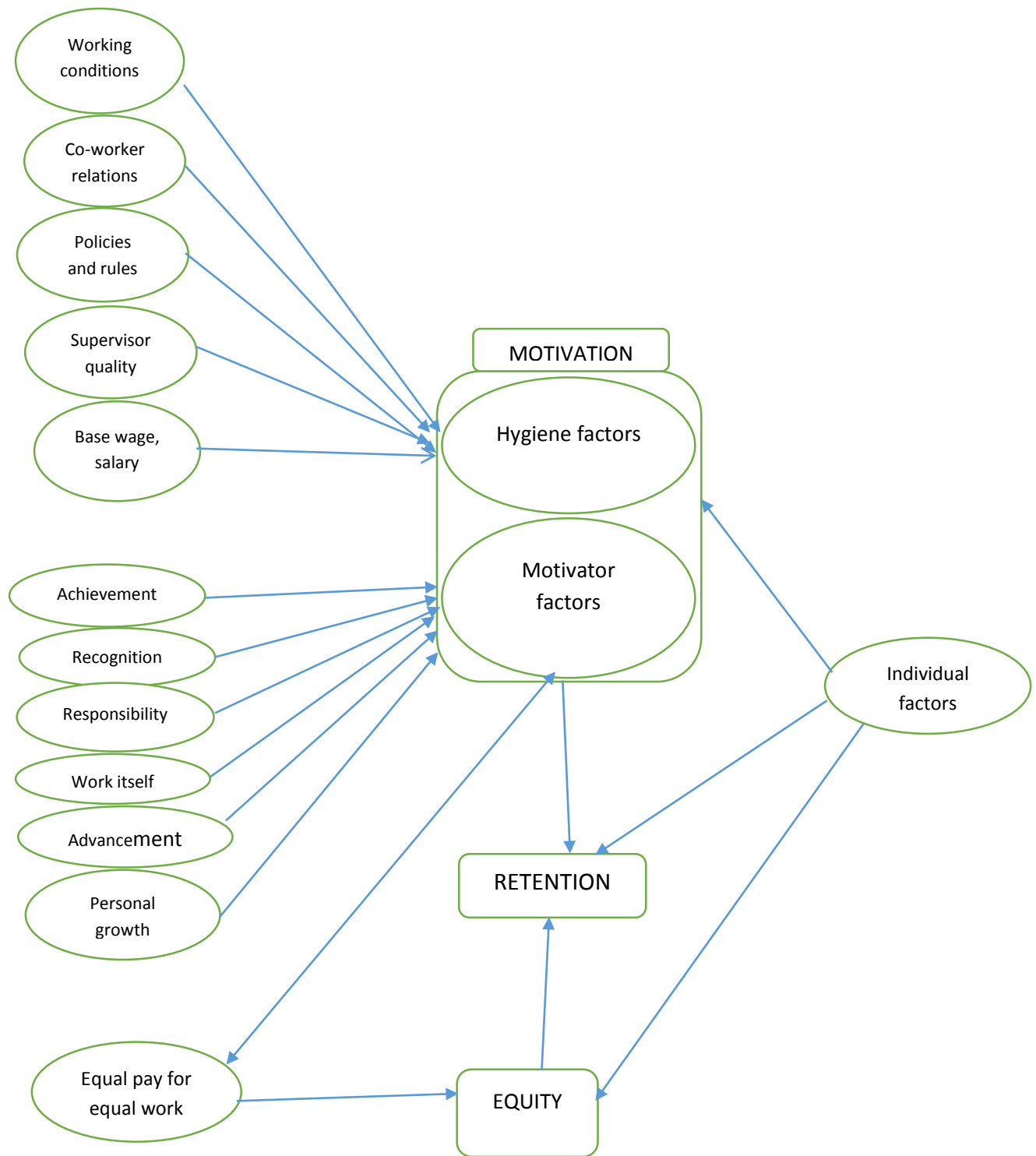
There have been various studies that support and validate the application of Herzberg's two-factor theory for research on employee motivation and retention. Chine (2013) tested the validity of Herzberg's two-factor theory and found it to be plausible to study motivation and retention among employees. The two-factor theory of Herzberg consists of hygiene factors and motivators. According to Herzberg, hygiene factors on their own do not motivate or satisfy employees. However, employees are dissatisfied when these hygiene factors are not present in the workplace (Alshmemri et al., 2017; Ghanbahadur, 2014). The above position of the theory implies that the combination of motivators and hygiene factors leads to employee satisfaction and motivation at the workplace (Herzberg, 2017; Pardee, 1990; Pugh, 2017). According to Herzberg (1974), things that make people unhappy in organizations has nothing to do with what they do but rather how poorly they are treated. These treatment factors are not related to work content, but the job content. Therefore, people who are dissatisfied with their jobs become unproductive, unhappy, less valuable, and sometimes feel like quitting their jobs, affecting retention.

2.3.7 Conceptual framework

Several studies have demonstrated that motivation positively impacts employee retention (Mgedezi et al., 2014), but the rate of retention differs due to certain factors (Glen, 2006). Motivated employees are more loyal and remain committed to the organization (Ajmal et al., 2015), which reduces employee turnover. Afenyo (2012), in his study of motivation effects on retention in a private sector in Ghana, found that motivation has a significant positive result on retention. Sajjad et al. (2013) also found that motivation has a significant effect on workers quitting jobs in Pakistan financial segment; this indicates the rise in motivation in-turn enhances employee retention. There are other factors such as individual characteristics like age, sex, religion, education, and marital status that influence a health tutors retention (Kanfer &

Ackerman, 2000; Ballenger et al., 1984; Kovach, 1995). Other individual factors, like the family background, marital status, among others, could influence a health tutors' retention. There is evidence demonstrating that rural upbringing increases rural practice (Lehmann et al., 2008; Dussault & Franceschini, 2006). It is, therefore, necessary for the ministry of health to consider these factors in motivating the health tutor to help retain them. Based on the theories of motivation, equity, and retention, a consolidated framework of the determinants of worker retention has been developed. The framework developed by this author below combines the theory of motivation with equity to determine worker retention. When workers are motivated and equitably treated at the workplace, the workers retain their jobs. On the other hand, when workers perceive unfair treatment at the workplace coupled with inadequate motivation, workers tend to leave the job for greener pastures elsewhere.

Figure 4: An integrated conceptual framework



Source: Survey, 2016.

There have been various studies that support and validate the application of Herzberg's two-factor theory for research on employee motivation and retention. Chien (2013) tested the validity of Herzberg's two-factor theory and found it to be plausible to study motivation and retention among employees. The two-factor theory of Herzberg consists of hygiene factors and motivators. According to Herzberg, hygiene factors on their own do not motivate or satisfy employees. However, employees are dissatisfied when these hygiene factors are not present in the workplace (Alshmemri, Shahwan-Akl, & Maude, 2017; Ghanbahadur, 2014). The above position of the theory implies that the combination of motivators and hygiene factors leads to employee satisfaction and motivation in the workplace (Herzberg, 2017; Pardee, 1990; Pugh, 2017). According to Herzberg (1974), things that make people unhappy in organizations has nothing to do with what they do but rather how poorly they are treated. These treatment factors are not related to work content, but the job content. Therefore, people who are dissatisfied with their jobs become unproductive, unhappy, less valuable, and at times feel like quitting their jobs which affects retention.

This conceptual framework concludes that for an employee to be motivated there needs to be a combination of hygiene factors and motivators in order to effectively motivate an employee. This conceptual framework concludes that for an employee to be retained at his job, the employee needs to be motivated and also equitably treated. There needs to be a combination of hygiene factors and motivators for an employee to be effectively motivated. The hygiene factors include the potential for the worker to achieve his/her aspirations, recognition of the worker by management, responsibilities assigned the worker, clear path for growth, and advancement in the hierarchy of the organization. The hygiene factors refer to clear company policies, relationships with colleagues and supervisors, work conditions, remuneration, salary, and job security. Equitable treatment at the workplace refers to how employees at the same rank are remunerated compared to others. Just as the two factors of motivation affect retention,

so too equitable or inequitable treatment at the workplace affects retention. Equitable treatment of the employee affects motivation and improves the chances of the worker retaining the job. The integrated conceptual framework applies to the subject matter of this study, which is the motivation, equitable treatment, and retention of health tutors in health training institutions in Ghana. The retention of health tutors at the various training institutions has been shown by this study to be primarily influenced by the motivation and equity that results in job satisfaction or dissatisfaction.

Summing up, figure 4, is an integrated conceptual framework which shows that work conditions, achievement, co-worker relationship, recognition excetera have an impact on motivation and motivation intend drive retention. Individual characteristics shape weather people are equity sensitive or not and this has an impact on retention. From the conceptual framework, individual factors, equity and motivation all drive retention.

2.4 Equity Theory

Theorist. The equity theory was propounded by John Stacey Adams (1963,1965). According to Adams (1963), what motivates or demotivates people to work is the perception of equitable and inequitable treatment in the workplace. Adams uses the concept of input and output to explain the motivation of workers. According to the theory, if the employee perceives inequity in the workplace, the employee will take measures to correct the inequalities by reducing their output or quality of work. Inequality in the workplace leads to resignation and late reporting to work (Greenberg, 1999). Employees respond to inequity in three ways: employees demand increases in benefit and another reward, thus increasing their outcomes (Hoy & Miskel, 2013). Secondly, workers are likely to like to leave or quit the job for another job, and finally, they decrease their effort by spending less time and effort on the job (Ryan, 2016).

The equity theory deals with human motivation that has broad implications for understanding human behaviour in an organization (Dugguh & Dennis, 2014). Equity theory helps organizations administer fairly the training needs of employees (Khan et al., 2015). Further, the theory supports the human resource department in their administrative tasks such as salary negotiation, promotion of staff, and staff improvement and development programs. The theoretical framework of equity theory helps human resource managers to understand the factors that motivate employees to be efficient and to understand employee's behaviour in the workplace (Osabiya, 2015).

Scholars of organizational theory consider equity theory the most useful theory of human behaviour (Armstrong & Taylor, 2014; Beardwell & Claydon, 2007; Forray, 2006; Foster, 2010). The equity theory explains how employees compare their contribution to the organization, thus inputting the reward they receive (outcome) with other employees or a group of employees (Buzea, 2014). The basis of this comparison is to ensure there is no inequity among employees performing the same task (Buzea, 2014). The employees performing this comparison uses different strategies to provide a balance between them and other employees (Armstrong & Taylor, 2014). Equity theory is useful for human resource practitioners because it links high performance to motivated employees (Armstrong & Taylor, 2014; Beardwell & Claydon, 2007).

Further, the equity theory is useful in designing career development systems, human resources planning, appraisal of workers, promotion performance guidance, and training (Buzea, 2014). According to many organizational theory scholars, equity theory is instrumental in applying to human resources processes such as performance management process, work motivation assessment, and total scheme of job design (Armstrong & Taylor, 2014; Beardwell, Holden, & Claydon, 2007; Forray, 2006; Foster, 2010). Many researchers have become interested in using the equity theory because they believe the theory provides a fair outcome. The concepts of

justice and equity is a cornerstone for employee working in the health sector. The healthcare sector considers the equitable and fair treatment of employees as an important organizational goal because the sector deals with the wellbeing of the human capital of a nation.

2.4.1 Context and Development of Equity Theory

John Stacey Adams developed the equity theory based on his workplace and behavioural psychologist (Carrell & Dittrich, 1978). Adam propounded the theory because of earlier theories of motivation, such as Maslow's hierarchy of need, Charles handy theory on extension and interpretation, and Herzberg two factor theory (Adams, 1963, 1965; Carrell & Dittrich, 1978).

According to Adams, all the workplace psychologist theorist of motivation acknowledge that subtle and variable factors affect employee assessment and perception of their work relationship and their employer (Adams, 1963, 1965; Carrell & Dittrich, 1978). However, Adams treated employee cognizance and awareness of their motivation to work and relationship with their employers in a broader situation. Also, Adam explained employee critical comparison of their output to their compensation stronger in equity theory than the other ideas on employee motivation (Adams, 1963, 1965; Carrell & Dittrich, 1978).

The underlying principle in Adam's equity theory is that employees are motivated by the perception that they are being treated fairly by their employer; in contrast, the employee feels disillusioned and demotivated when they perceive that their employee is maltreating them (Adams, 1963, 1965; Carrell & Dittrich, 1978). The equity theory, therefore, explains the way employees measure fairness or unfairness in an organization.

The new perspective of equity is based on the demographical background and psychological variables of an individual to consider themselves or other people as being treated equitably effectively or not (Liu, & Berry, 2013). The proposal of the equity sensitivity construct, a new

perspective of the equity theory, is that employees behave consistently concerning equity; however, individual differences in perception determine whether the employee believes he or she is being treated equitably or otherwise (Buzea, 2014; Liu, & Berry, 2013).

The new perspective of equity theory identifies three classes of individual preference that determine how they perceive equity and inequity (Allen et al., 2015; Liu, & Berry, 2013; Gelens et al., 2013). They are benevolent, which means some employees prefer to have their outcome/input ratio less than the outcome/input ratio of other employees (Kaur et al., 2014). The second class of employees is also called equity sensitive because they confront the traditional norm of equity and prefer that their output/input ratio will be the same as other employees (Kaur et al., 2014). Finally, those called entitled believe that their outcome/input ratio should exceed other employees (Kaur et al., 2014).

2.4.2 Constructs of Equity Theory

Input. There are a few kinds of research that explain inputs as a construct of equity theory. According to Kim et al. (1990), inputs can be categorized into task input and maintenance inputs. Kim et al. (1990) defined task inputs as activities of employees that are directly related to their accomplishment and goal; and maintenance input as socio-emotional support to preserve group cohesiveness (Buzea, 2014, p. 423).

Input is the work effort of employees, including maintaining group harmony in the organization. Other researches also identify the following as the input construct of equity theory: individual work performance, education, seniority, work effort, and family size (Buzea, 2014). According to Buzea (2014), some employees believe in performance as their inputs, and others focus on education, seniority, and family size. Notwithstanding, this construct gives

information to the human resources unit of an organization to practice the human resource principle that ensures fairness and employee satisfaction (Beardwell et al., 2007).

Output or Outcome. Output or outcome is the expectations of the employee in terms of compensation and other benefits of the employees, such as promotion and incentives associated with their work (Buzea, 2014). Employees expect to be rewarded according to their work effort and contribution (Ake, 2017). They turn to compare their efforts and compensation with other employees of the organization. If they discover an imbalance in the reward system, it causes job dissatisfaction (Sert et al., 2014). The employee sees this issue as a procedural justice; thus, how the reward is allocated fairly among employees (Ake, 2017). The recognition of this behaviour by employees in an organization is very significant in human resources practices. Scholars of theories of organizational behaviour refer to the comparison of employees in terms of their work effort and the commensurate reward or compensation as an input-output ratio (Ake, 2017; Beardwell et al., 2007; Sert et al., 2014).

Referent. There is limited research on this construct of the theory. According to Buzea (2014), employees use referents to examine the ratio of fairness by evaluating their input against their output. One of the limitations of equity theory is the lack of elaboration of mechanism which employees use in determining referent (Buzea, 2014). However, Adam (1963) assumed that employee referent is usually their co-workers, relative, past co-workers, and neighbours doing the same job or in the same category of the job description.

Meanwhile, critiques of this construct raise three issues concerning referent in terms of what criteria employees apply to select referent, what is the acceptable number of referents an employee can rely on, and the level of stability of the choice of referent by the employee (Gomez-Mejia et al, 2014). The response to these issues is that employees select referent using two factors: the availability of information on other employees' input, output, and the relevance of the referent (Buzea, 2014; Goodman, 1974).

2.4.3 Response to Inequity

Employees usually adjust their behaviour in response to inequity in an organisation (Bidwell et al, 2013). Some scholars believe employees response to injustice can be categorized into two primary forms, the response of employees focused on restoring psychological equity and the response of an employee to restoring actual equity (Bidwell et al., 2013; Hegtvedt & Isom, 2014). The response of an employee to restore psychological needs involves employees changing their perceptions of input and outputs to restore equity (Dugguh & Dennis, 2014). On the other hand, employees restore actual equity by altering their referent inputs and output, thus, reducing the effort they put into work demand salary increment (Buzea, 2014; Dugguh & Dennis, 2014). Even though there are limited studies on this construct, some theorist agrees that the cultural background of an employee determines the response to equity of an employee (Bolino et al, 2013; Stedham & Beekun, 2013).

2.4.4 Alignment of Equity Theory with the study

The theory aligns with the purpose and the aim of the study because this research aims to examine the motivation and retention of tutors of public health institutions of Ghana. The theory was developed to explain employee perception of motivation in a more comprehensive way that other theories of motivation do not cover (Adams, 1963, 1965; Carrell & Dittrich, 1978). Again, the theory was purposely designed to explain employee's motivation instead of general motivation theory (Adams, 1963, 1965; Carrell & Dittrich, 1978). The equity theory's premises of employee adjustment of their behaviour in response to inequity in an organization aligns with the research problem of this study (Bidwell et al., 2013). The tutors of public health institutions are demotivated and migrating to urban cities for better conditions of service.

Therefore the researcher believes that the equity theory's framework fits to explain this phenomenon.

Some scholars believe an employee's response to inequity can be categorized into two primary forms, the response of employees focused on restoring psychological equity and the response of an employee to restoring actual equity (Hegtvedt & Isom, 2014). The response of an employee to restore psychological needs involves employees changing their perceptions of input and outputs to restore equity (Dugguh & Dennis, 2014). On the other hand, employees restore actual equity by altering their referent inputs and output or asking for increment in salary (Buzea, 2014; Dugguh & Dennis, 2014). This argument will help the research to understand the phenomenon of employee motivation retention of tutors of the public health training institution. The Ghana public health training institutions issue of employee migration from a rural area to the cities results from job dissatisfaction and poor working conditions or opportunities in rural areas. Therefore, the equity theory will help the researcher to understand and explain why the tutors are migrating to urban areas to work.

Strengths. The application of the theory to studies on employee motivation provides a framework for understanding factors that motivate employees to stay in an institution and those that make them dissatisfied. The theory suggests ways to motivate and retain employees in an organization (Davic et al., 2015; Huseman et al, 1987). Also, the theory combines perfectly with other theories for research purposes (Burton-Jones & Grange, 2013). The equity theory particularly fits with the expectancy theory. For example, in this study, the researcher combines the equity theory with Herzberg two factor theory.

According to Stetcher and Rosse (2007), the theory can predict employee equitability, and based on their confirmation, and the employee can apply expectancy theory to act on equity. This assertion of Stetcher and Rosse (2007) implies that the theory helps researchers to predict accurate employee behaviour exceptionally in cases where employees are underpaid, or

employees experience unfair treatment (Bosse & Phillips, 2016). The theory makes research sense based on the assumption that people compare their input and outcome concerning other employees of an organization (Stetcher & Rosse, 2007).

Weaknesses. In typical research using equity theory, participants are asked to respond to specific research questions to compare inputs with outcomes (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978). This situation forces participants to go through a cognitive process in answering research questions; however, the cognitive process may not be used for the research (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978). Again, the specification variables and referent persons may not be relevant or have little relevance to the equity subject in a particular situation (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978).

Equity theory uses simplified limited questions by presenting a limited variable of the theory not to confuse the research participants (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978). However, multiple variables model would be a plausible, more powerful, and more realistic than a simplified limited variable (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978). It is worth mentioning that even using multiple variables of the theory; thus, a typical input/outcomes comparison process is difficult to operationalize (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978).

Some research suggests that the perception of research participants about fairness in the treatment of themselves and others are not related to the only reward of their output and other forms of compensation, but also related to the organization's system of reward allocation (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978). Thus, though employees compare their reward or compensation with other workers as the basis for their perception of fairness, the employees forget to consider the structure of the reward system in the organization (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978). Therefore, the assessment of equitability may be more with the organization than a co-worker. This situation means employees that feel unfairly

treated adjust their output based on the wrong premise of comparison (Bakker & Demerouti, 2014; Carrell & Dittrich, 1978).

According to Carrell and Dittrich (1978), the approach of the theory in measuring perception of equity and the net balance is more fruitful. Thus, this approach may assess the perception of equity and its effect or impact on net balance or the overall fairness relationship of input/outcome ratio of an employee and co-worker comparison. Instead of specified comparison with a co-worker, the employee is allowed to the internally derived standard of comparison as suggested by equity researchers (Austin & Walster, 1974; Goodman, 1974; Lane, & Messé, 1972; Middlemist & Peterson, 1976; Weick & Nasset, 1968; Zedeck, & Smith, 1968). Comparing an employee inputs/outcome with standards derived internally will result in an overall feeling of fairness about the relationship of all elements in the original equity inputs/outcomes model (Adams, 1963; Adams, 1965)

2.4.5 Application of the Theory

The equity theory impacts this study in three broad ways. The first perspective is using the theory to describe the relationships between the tutors of health training institutions in Ghana and organizational outcomes such as motivation and retention (Davick et al., 2015; Huseman et al., 1987). Using the equity theory as a theoretical framework helps to provide boundaries for the explanation of how input/output ratios of colleague health tutors provide a basis for comparing rewards and its effects on their motivation to continue in the teaching profession or to look for some other employment opportunities (Davick et al., 2015; Huseman et al., 1987). The application of the theory to the research will help the researcher to examine the impact of equity and inequity on the variable of health training institution such as quality of work of the tutors, the quantity of work, tutor turnover, and job satisfaction (Davick et al., 2015; Huseman et al., 1987). The theory will also help the researcher explain the relationship between job

satisfaction and equity and prediction of tutor performance in rural and urban areas (Davick et al., 2015; Huseman et al., 1987).

Apart from employee performance prediction, the theory also predicts job satisfaction of employees in an organization, which one of the issues of the researcher will be examining in this research (Davick et al., 2015; Huseman et al., 1987). According to the theory, over reward leads to dissatisfaction, and guilt increases employee output (Davick et al., 2015; Huseman et al., 1987). In contrast, under reward leads to resentment, anger, which results in absenteeism and low productivity. The theory is, therefore, a perfect match for this study.

CHAPTER 3

PROCEDURES AND METHODS

3.1 Introduction

The purpose of this mixed methods study is to examine how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana. An exploratory sequential design will be used first to explore qualitatively to develop a context-specific and sensitive quantitative survey instrument to be administered to a large sample of tutors in public health institutions in Ghana. The overarching research question of this study is: How are the tutors of public health training institutions motivated and retained at their posts in a rural or urban area of Ghana? The specific research questions of the study are:

1. What are the factors that motivate the tutors of public health training institutions into tutorship in Ghana?
2. What are the factors that motivate the tutors of public health training institutions to stay at their posts in a rural or urban area of Ghana?
3. How equitable do tutors bring the inputs to public health training institutions and the outcomes they receive in a rural or urban area of Ghana?
4. To what extent and in what ways does the quantitative results confirm the qualitative data that tutors from urban public health training institutions are better motivated, equitably resourced, and retained at their posts than their counterparts in the rural areas?

The chapter discusses the methodology that is used to examine the research questions. The first section of the chapter provides a discussion of the philosophical underpinnings of the methodological design. The section concludes with a review of the strengths and weaknesses of the mixed methods study. A discussion of the research design is followed by a description of the characteristics of the research sites where the data were collected. The discussion

includes how this researcher gained access to the sites and how the sites and research participants are representative of the phenomenon under study.

The discussion of the research site is followed by a description of the characteristics of the overall population in which the research problem manifests. This discussion includes a description of the sample population and its representativeness. The characteristics of the research participants in the exploratory qualitative segment and the quantitative portion of the study are described. A discussion of research participants is followed by explaining the sample size, power analysis, and target sample for the quantitative participants. This segment contains a description of the participant selection process and the type of sampling used, why the number and unit of analysis were selected, the criteria used for inclusion in the sample, and a step-by-step account of how the sample was selected. The section on the population and research participants are concluded with a discussion of the permissions obtained to conduct the study. The data sources are discussed next. The section articulates the sources the researchers used to collect the data. The data sources included focus group discussions, interviews, and surveys and a discussion of their advantages and disadvantages, and their relevance to the study. The research protocols and instruments used and how they were obtained for the study are explained. Issues of reliability and validity of the research protocols and instruments are discussed in this section.

The explanation of data collection procedures follows the section on data sources, instrumentation, and credibility issues. This section explains all of the data collection procedures before the study, during the study, and after the study, using a detailed description of how the data collection originated and concluded. A discussion of the positionality of the research is explained in this section. The positionality of the researcher describes the lens through which the researcher interprets the social world, and how the researcher's background

influenced data collection and analysis, including social and professional relationships and particular life experiences.

The data analysis and techniques are next. This section discusses the methods used to analyse the data, and based on the research questions and purpose of the study, why they are the most appropriate techniques. The chapter concludes with a summary of the significant issues raised in this methodology chapter. The summary also shows how the research problem, the purpose of study, research questions, the theoretical frameworks, and the procedures and methods align.

3.2 Research Design

This study uses the exploratory sequential mixed methods approach. Johnson, Onwuegbuzie, and Turner (2007) asserted that mixed methods studies “combined elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration” (p. 123). Creswell and Plano Clark (2018) suggested that using a mixed methods approach was valuable when the collection of one type of data may not provide the information needed to answer the study’s research question. Johnson and Onwuegbuzie (2004) indicated that the use of mixed methods permitted researchers to design a study to provide the researcher with the best opportunity to explore a research question.

According to Creswell and Plano Clark (2018), all research designs are underpinned by a set of broad assumptions that are termed “worldviews” (p. 35). They further asserted that the specific worldview of the researcher serves as a philosophical lens through which the researcher looks at a research phenomenon, including the theoretical framework, the methodological approach, and the data collection methods. Creswell and Plano Clark further asserted that mixed methods research is subsumed under one of four worldviews. These four worldviews included: positivist, constructivist, transformative, or pragmatist worldviews. The

underlying assumptions of each worldview inform how the researcher conducts a study based on a chosen research methodology. (Creswell & Plano Clark, 2018; Sommer, 2011). The philosophical worldview that suits the mixed methods design of this study is pragmatism.

3.2.1 Pragmatism

Creswell and Plano Clark (2018) asserted that mixed methods research is associated mainly with the pragmatism worldview. According to Creswell and Plano Clark, the pragmatist worldview focuses mostly on the research problem rather than on the method used to investigate the issue. Secondly, the pragmatist worldview is concerned with the consequences of the research. Thirdly, it focuses on using multiple methods of data collection to address the research questions rather than a single method. Finally, the pragmatist worldview is interested in what practically works in the real-world than theoretically. Creswell and Plano Clark's assertions are upheld by Johnson and Onwuegbazie (2004), who also asserted that pragmatism as a philosophical foundation for mixed methods provides a "workable solution" (p. 16) to problems.

To pragmatists, the reality is an ongoing interaction between individuals and the world around them (Dewey, 1925). As a current phenomenon, the individual reality is not static but continually changing as the individual continues to interact with the environment (Dewey, 1925). The fluidity of the interactions between the individual and the surrounding world makes it impossible for the individual to hold onto a single reality or truth (Stark, 2014). Stark further asserts that time and circumstances set the boundaries to what an individual deems as reality or the truth at a set time. As a result of the boundaries time and circumstances place on reality and truth, to the pragmatist, reality and truth will be perceived differently not only by different individuals but by the same individual at various set times (Hammond, 2013; Stark, 2014).

Pragmatists assert that in addition to the perception of reality being influenced by the interactions between the internal and external worlds, the knowledge acquired by the individual through these interactions is also impacted (Jenkin, 2016; Stark, 2014). Additionally, the knowledge gained from the interactions between the internal and external worlds are not always consumed immediately but also stored for future use (Dewey, 1938). Knowledge generated from the interactions with the internal and external worlds is created in response to the need for specific solutions to emergent problems (Hammond, 2013; Harney et al., 2016). Pragmatists further believe that there cannot be a separation between the individual and the knowledge they create based on their interactions with the world around them (Morgan, 2014).

Individual values are at the core of how they perceive truth and reality (Morgan, 2014; Dewey, 1925). Individuals do not interact with the world around them in a cold, dispassionate manner, but these interactions are geared to solving problems based on individual values (Morgan, 2014; Dewey, 1925). A person's values emanate from the "claims of the thing in question to be esteemed, appreciated, prized, cherished" (Dewey, 1925, p. 332). Morgan (2014) argued that values and beliefs influence how individuals interact with the world around them and therefore influence the reality they perceive and the way they perceive it. Values do not only shape what is essential to the individual, but it also influences how the individual interacts with the surrounding world (Neville, 2015).

From the explanations provided above on pragmatism, this researcher views this philosophical worldview as the appropriate philosophical paradigm underpinning his use of an exploratory sequential mixed-method for this study. First, the researcher ground the phenomenon being studied within what the research participants perceive as their present reality. Secondly, their reality is founded on their interactions with the environment within which they reside. The research participants and researchers believe that the motivating and equity issues of health tutors are environmentally influenced. Health tutors choose to live or stay in a rural or urban

area because of the interpretation of their interactions with their environment. Finally, the philosophical worldview of pragmatism has informed the choice of mixed methods because the researcher believes in the value of creating knowledge to address contemporary issues that have relevance for the future.

3.2.2 Strengths and challenges

All research designs have strengths and weaknesses, and mixed-method study is no exception (Privitera & Ahlgrim-DeLzell, 2019). The historical argument for the importance of mixed methods is that the design harnesses qualitative and quantitative approaches to balance their weaknesses (Creswell & Plano Clark, 2018). It is argued that quantitative designs are weak in capturing the setting and context in which the study is conducted and that quantitative researcher removes their subjectivities when conducting the study. Qualitative research, therefore, comes in to offset the weaknesses associated with quantitative design. On the other hand, qualitative studies are weak in upholding objectivity, and their findings cannot be generalized to a larger population. Therefore quantitative design balances the weakness of qualitative design (Creswell & Plano Clark, 2018).

Mixed methods design can combine quantitative and qualitative data collection and analysis (Creswell & Plano Clark, 2018). However, mixed methods research design cannot be used to study research questions that lend themselves to only quantitative or qualitative design. For a mixed method design to be used, the research question must demand the use of both quantitative and qualitative data collection tools and analysis (Privitera & Ahlgrim-DeLzell, 2019).

Two main conditions determine the appropriateness of mixed methods design. The first condition is that the research question for investigation must both be a process and an outcome question. If the research question is solely a process question or an outcome question, mixed

methods would not be a suitable design (Privitera & Ahlgrim-Delzell, 2019). Qualitative designs are interested in process research questions, and quantitative designs are interested in outcomes (Privitera & Ahlgrim-Delzell, 2019). The second condition for the appropriateness of mixed methods is the capability to integrate the findings from both designs. If the results of the qualitative segment of the study cannot be integrated with that of the quantitative design, then a mixed methods design is not suitable (Privitera & Ahlgrim-Delzell, 2019).

Strengths of mixed methods design. A significant advantage of mixed methods design is its distinctive ability to combine quantitative and qualitative research methods to enable the research issue to be addressed from both perspectives (Privitera & Ahlgrim-Delzell, 2019). There are specific research questions that a single research approach cannot adequately answer, and those research issues are reserved for mixed methods approach (Creswell & Plano Clark, 2018). Mixed methods allow for the use of multiple worldviews and give the researcher the freedom to practically use all research methods available to address a research problem (Creswell & Plano Clark, 2018).

A second necessary strength of mixed methods design is its ability to expand the scope of the study. The combination of the breadth of quantitative research comes from the use of large samples for generalization and the depth of qualitative research, which results from the thick and rich description of the “how” and “what” happened to research participants (Privitera & Ahlgrim-Delzell, 2019). The ability to expand the scope of the study also comes with the need to increase and expand the resources required for a mixed methods study. The expansion can expose the researcher to other research techniques and thereby improve the researcher’s research skillsets (Creswell & Plano Clark, 2018).

Mixed methods design can address complex research issues that may be difficult to study using a single research design (Doyle, Brady, and Byrne, 2009). Complex research problems require a comprehensive design that deploys all data collection and analysis techniques. This can only

be assessed by integrating quantitative and qualitative designs, and mixed methods are the only research design that requires integrating findings from different research designs (Privitera & Ahlgrim-Delzell, 2019). Mixed methods research produces results that are more than the sum of two parts (Creswell & Plano Clark, p. 13- 2018).

Challenges of mixed methods design. The opportunity mixed methods provide researchers to combine qualitative and quantitative designs to address complex research problems comes with the challenge of having requisite skills in both quantitative and qualitative approaches (Creswell & Plano Clark, 2018). The inability of a researcher to skillfully design a study using both quantitative and qualitative methodologies, including data collection and analysis techniques, makes it practically impossible to use mixed methods as a design (Privitera & Ahlgrim-Delzell, 2019; Creswell & Plano Clark, 2018).

The number of material resources needed to conduct a mixed methods studies successfully can be a challenge (Privitera & Ahlgrim-Delzell, 2019). Funding is a significant challenge in a mixed methods study (Venkatesh et al., 2013). The amount of time needed to conduct a mixed methods study, particularly explanatory sequential or exploratory sequential mixed methods study, can be time-consuming (Doyle et al., 2009). Where a researcher is not conversant with a particular research design, the researcher may need to spend time to first build the competency in the design before engaging in the actual study (Johnson & Onwuegbuzie, 2004).

Privitera and Ahlgrim-Delzell, (2019) asserted that although mixed methods can be used to study complex issues outside the domain of single research design, the study of complex problems also requires expertise in designing the study and interpreting the complex findings of the study. To synthesize information about the results of complex research and to understand those complex findings requires the skills of an expert. Without having a solid grounding in analyzing complex research issues, including integrating quantitative and qualitative data, a mixed methods approach becomes a challenge (Creswell & Plano Clark, p. 13- 2018).

3.2.3 Exploratory Sequential Mixed Methods

This study used the exploratory sequential mixed methods approach. An exploratory sequential mixed method design first gathers qualitative data, which is then used to guide the quantitative research (Privitera & Ahlgrim-Delzell, 2019). The rationale for using exploratory sequential mixed methods design is to ground the development of quantitative measures such as surveys in qualitative data (Creswell & Plano Clark, 2018).

Qualitative methodologies are used to explore meanings, descriptions, concepts, understandings, and characteristics of phenomena (Berg, 2001). The researcher collected the qualitative data first to ground the quantitative measures in the knowledge and perspectives of research participants to enable them to see the relevance of the data collection instruments (Creswell & Clark, 2018). The reason why the design is called *exploratory* sequential mixed methods is that qualitative study is best suited for exploring a phenomenon (Creswell & Plano Clark, 2018).

An exploratory sequential mixed methods design is useful when measures, instruments, or experimental activities are not available, or variables are not well defined, or there is no theoretical framework, or there is a need to make an instrument specific to the participants' culture as possible (Creswell & Plano Clark, 2018). The exploratory sequential mixed methods design is being used in this study so that the variables of the study can be culturally relevant to the group being studied.

Using an exploratory sequential mixed methods design enabled the researcher to gain more in-depth insight into how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana. By first exploring the research phenomenon using a qualitative approach, the researcher used the quotes, codes, and themes from the data analysis to develop a culture-specific survey instrument that was relevant (Creswell, 2014). The quotes

from the qualitative study were used to write the survey items, the codes were used to develop the variables that grouped the items, and the themes were used to group the codes into measurement scales (Creswell, 2014).

3.2.4 Case Study

As part of the qualitative exploratory section of the study, there will be a focus on presenting typical cases that highlight the phenomenon for emphasis. According to Yin (2012), a case is a bounded entity (person, organization, behavioural condition, event, or another social phenomenon), but the boundary between the case and its contextual condition in both spatial and temporal dimension may be blurred (p. 6). The cases that were selected focused on what Patton (2015) referred to as an exemplar of a phenomenon of interest” (p. 273). Cases that are of exemplar of a phenomenon of interest offer insights into the phenomenon and stand alone as important. It is important to note that the exemplar of a phenomenon is cases that are purposely selected by the researcher to draw attention to the intrinsic value of the case (Patton, 2015).

3.3 Site Selection

A multi-step process was used in selecting the research sites for this study. The first step used the definition of rural and urban to segment the country into two zones. The north represented the rural areas, and the south represented the urban areas of Ghana. The zoning into rural and urban is based on the Ghana Statistical Service (GSS) definition of rural and urban areas. A rural area is a sparsely populated geographic location with clustered populations of less than five thousand people. The majority of towns and cities are above five thousand; that cluster is considered an urban area (GSS, 2012). Compared to the north of Ghana, the south is geographically built-up with towns and villages having populations above five thousand

people. Below is a map of Ghana showing the zoning of the country into northern and southern Ghana. Northern Ghana is representing the rural areas, and Southern Ghana representing the urban areas of the country.

Figure 5: Map of northern and southern Ghana



Source: Google maps, 2016.

Study participants were drawn from eight public health training institutions from the north and an equivalent number of eight from the south. These research sites were purposefully selected to study the phenomenon under investigation. Purposeful sampling refers to the intentional selection of cases such as people, organizations, cultures, communities, events for study based

on the ability of the cases to provide in-depth information that is useful for understanding the phenomenon under investigation (Patton, 2015). The sites selected in the north were the Health Assistants Training School in Kpembu, Health Assistants Training School in Nalerigu, Health Assistants Training School in Bole, Health Assistants Training School in Yendi, Health Assistants Training School in Damongo, Midwifery Training College in Gushiegu, Zuarungu Nurses and Midwifery Training College, and Kintampo College of Health.

The research sites selected in the south included Korle-Bu Nursing Training College, Korle-Bu Midwifery Training College, Okomfo Anotie Nurses Training College, Okomfo Anotie Midwifery Training College, and Ridge Anaesthesia Training College, Korle-Bu Peri-Operative Nurses Training, Korle-Bu Ophthalmic Nurses Training, and Korle-Bu School of Hygiene.

Table 9: Research Sites and Tutor Populations

Rural Area			Urban Area		
Name of Institution	Tutor Population		Name of Institution	Tutor Population	
	Male	Female		Male	Female
Health Assistants Training School in Kpembu	22	42	Korle-Bu Nursing Training College	86	66
Health Assistants Training School in Nalerigu	34	58	Korle-Bu Midwifery Training College	76	43
Health Assistants Training School in Bole	26	38	Okomfo Anotie Nurses Training College	82	72

Health Assistants Training School in Yendi	24	40	Okomfo Anokye Midwifery Training College	73	38
Health Assistants Training School in Damongo	27	36	Ridge Anesthesia Training School,	25	15
Midwifery Training College in Gushiegu	28	39	Korle-Bu Peri- Operative Nurses Training	15	17
Zuarungu Nurses and Midwifery Training College	29	49	Korle-Bu Ophthalmic Nurses Training	17	12
Kintampo College of Health.	122	58	Korle-Bu School of Hygiene	30	61
TOTALS	312	360		404	324

Source: Survey, 2016.

To gain access to the research sites, the researcher wrote letters to the various principals informing them of the study and asked permission to conduct the study. Letters were written to sixteen principals made up of eight from the rural areas and eight from the urban areas. All the sixteen principals gave their permission for the research to be conducted in their institutions. After that, the researcher wrote letters to all the tutors in the sixteen institutions. Letters were written to 1,400 tutors being the total number of tutors in the sixteen research sites. The letter informed the tutors of the purpose of the study, the date and time the researcher would be on the institution campus to collect data, and a request for those interested in the study to respond. All 1,249 tutors responded positively, indicating their willingness to participate in the study.

3.4 Participants

The study participants were 1,400 tutors from selected 16 health training institutions in Ghana. All the 16 health training institutions were public institutions operating under the Ministry of Health. The participants for the study were 716 male tutors and 684 female tutors. Participants from the eight selected health institutions of rural north were 312 males and 360 female tutors. Those from the eight urban south institutions were 404 males and 324 female tutors. The tutors were within the ranges of 20 years and 59 years of age. Most of the participants were married or have been married before (80%). Most (98%) of the participants were adherents of one religious faith or the other. Some of the participants had a bachelor's degree (45%). Some had a master's degree (40%), and a few of them had doctorate degrees.

3.5 Participant Selection

Qualitative study. This study was an exploratory sequential mixed methods study and therefore required that the first participants be selected to participate in the exploratory qualitative segment of the research. According to Creswell (2014), there is no specific answer to how many sites and participants should be involved in qualitative research. The researcher, therefore, used a purposive sampling technique to select cases that were rich in providing information to illuminate the research issue. The purposive sampling method was first used to choose the number of training institutions whose tutors participated in the study. Five training institutions in the rural north and five in the urban south of Ghana were purposively selected. Teddlie and Tashakkori (2009) defined purposeful sampling as selecting units based on specific purposes associated with answering a research study's questions (p. 170).

According to Patton (2015), nothing distinguishes qualitative design from quantitative research than purposefully selecting information-rich cases from which one can learn a great deal. He

further stated that purposive case selection is the foundation of qualitative inquiry. Based on the explanation on purposive sampling, the researcher selected health training institutions from which health tutors and principals were drawn from for data collection: the five northern rural health training institutions selected were Health Assistants Training School in Kpembu, Health Assistants Training School in Nalerigu, Health Assistants Training School in Bole, Health Assistants Training School in Yendi, and Health Assistants Training School in Damongo. Research participants were drawn from the following southern urban health training institutions: Korle-Bu Nursing Training College, Korle-Bu Midwifery Training College, Okomfo Anotie Nurses Training College, Okomfo Anotie Midwifery Training College, and Ridge Anaesthesia Training College.

The next level of participant selection was according to the technique of criterion-based case selection. According to Patton (2015), criterion-based sampling involves the use of criteria, and all cases that meet the criteria are selected for the research. The criteria used to select the study participants for the exploratory qualitative study were age brackets. A list of all tutors was obtained from the Input Personnel Processing Data office of the Ministry of Health. The tutors were grouped into ages. The first age bracket were those within the ages of 20 to 29, and the second were those within the ages of 30 to 39, the third group was those in the age bracket of 40 to 49, the fourth and final group were those within the age bracket of 50 to 59.

Three data sources were used for the exploratory qualitative study. The first was focus group discussions, followed by in-depth interviewing and key informant interviews. Participants were selected for the focus group discussions according to the criterion-based case selection technique. The third qualitative data source which interviewed key informants used the key knowledgeable and reputational sampling technique to select the cases for interviewing. Critical knowledgeable and reputational sampling involves identifying people with excellent knowledge and influence who can shed light on the research phenomenon (Patton, 2015).

Quantitative study. Participants for the quantitative study were drawn from eight rural health training institutions from the north and eight urban health training institutions from the south. These institutions are listed in Table 9 above. A simple random sampling technique was used to select research participants for the quantitative study. Simple random sampling is a method in which the required number of elements or units are selected simply by random method from the target population. As a probabilistic sampling method, the intention is to select many research participants to represent the population of interest (Creswell & Plano Clark, 2018). Polit and Beck (2004) defined a sample as a proportion of a population. Burns and Grove (2003) referred to sampling as a process of selecting a group of people, events, or behaviour with which to conduct a study. The sample size for the study was calculated using Krejcie and Morgan's (1970) formula: $s = X^2 NP (1 - P) / d^2 (N - 1) + X^2 P (1 - P)$.

Where:

- s = required a sample size
- X^2 = the table value of chi-square for 1 degree of freedom at 95% confidence level = (3.841)
- N = the population size.
- P = the population proportion (assumed to be 0.50 since this would provide the maximum sample size).
- d = the degree of accuracy expressed as a proportion (0.05).

The sample size for 1,400 tutors from the 16 health training institutions was 302. However, 171 tutors from the south and 158 tutors from the north participated in the study bringing the total to 329 participants.

Table 10:The sample size for the quantitative study

Region	Population	Sample size
Urban South		
Nursing	642	151
Allied Health	86	20
Sub-total	728	171
Rural North		
Nursing	520	122
Allied Health	152	36
Sub-total	672	158
Total	1,400	329

Source: Survey, 2016.

Note: Estimated sample size by the author based on Krejcie and Morgan (1970) known sample size calculation. Population sizes for the two regions are all approximated based on a 10% estimation of total nursing workers population in the regions presented in the Ghana Health Worker Observatory report (2011). The sample size figures are also rounded off to enhance the representativeness of the sample size further.

3.6 Ethical Permissions

Although no ethical issues were surrounding this research because the study participants were not children or vulnerable populations, the researcher obtained ethical clearance from the Research Ethics Committee of the Queen Margaret University to conduct this study. The ethical considerations for this study were limited to those that apply to mixed methods research contained in various ethical behaviours for research documents. The three ethical principles

that apply to this study are respect for persons, beneficence, and justice. In applying these principles, the researcher ensured that research participants were treated as autonomous agents. The research study did not diminish the autonomy of participants in the study.

Research participants were given information about the research, both verbally and in writing, before being asked to sign a consent form. The consent form was prepared in English, as participants were all well-educated and preferred to use English. All research participants were given time to read the information carefully about the project before deciding whether they would like to participate. Participants were asked if they had any questions, problems, or objections related to the project before commencement. The consent sheet contained information about the background of the research project. Participants were made to understand that participation in the study was voluntary and that the research participants could decide not to answer particular questions or to withdraw from the research at any time without detriment or consequences. The consent sheet also contained information on the clearances and approvals obtained for the research from QMU and MOH-Ghana. Participants were also informed that the information they gave would be treated confidentially by the researcher and that the research assistants had signed a declaration of privacy. The consent form also contained the full contact details of the researcher.

The researcher treated them with respect, including respecting their decision to withdraw from the study at any given time. Secondly, the researcher followed the principle of beneficence, which demands that no harm is done to research participants, and ensuring that research participants benefited from the study. The identities of the research participants of this study were kept anonymous to protect them from any potential harm from their workplaces. The final ethical principle observed by the researcher was justice, which concerns the determination of who gains the benefits and bears the burdens of the research. The research participants of this study did not take any responsibility nor gained any direct benefits. All tutors of health training

institutions in Ghana at large may benefit from this study in the future if policymakers use the results of the study for decision making.

To gain access to the health training institutions, the researcher first applied to the Institutional Review Board of the Ministry of Health and obtained approval to conduct the study. Secondly, the researcher wrote letters to all the 16 principles to obtain permission to enter their institutions to conduct the research. After obtaining permission, the researcher wrote letters to all 1,400 tutors to gain their consent to participate in the study. Attached in Appendix 1 is the Institutional Review Board of the Ministry of Health approval letter to conduct the research.

3.7 Data Sources

Qualitative study. Three sources of data were used to obtain data for this study. In the exploratory qualitative segment of the study, a focus group semi-structured questions and a semi-structured interviewing protocol were used for a focus group discussion and in-depth interviews, respectively. A focus group is an interview with a small group of a minimum of three and a maximum of eight people where participants interact in response to questions posed by the researcher (Privitera & Ahlgrim-DeLzell, 2019). Patton (2015) refers to interviews as an interaction, a relationship where open-ended questions and probes by the interviewer provide the researcher with in-depth responses about the knowledge, experiences, perceptions, feelings, and opinions of the interviewee. Creswell and Poth (2018) also asserted that knowledge is constructed when an interaction occurs between a researcher and an interviewee. Other advantages of interviewing are that they are flexible, they allow the interviewer to enter into the interviewee's perspectives, the conversation moves to unexpected but fruitful topics which end up becoming the most valuable part of the interview (Smith et al., 2009). Interviews also have the advantage of providing the researcher with in-depth answers to research questions in the form of thick and rich descriptions (Patton, 2019). There are several disadvantages

associated with interviewing as a data source. Creswell and Poth (2018) asserted that interviewing can allow power dynamics between the interviewer and interviewee to affect the interview data. Secondly, the interviewee may not be forthcoming with adequate responses to the interview questions (Creswell & Poth, 2018). What the researcher did to avoid the disadvantages of interviewing was to remain open and sensitive to the power dynamics, which could affect the interviews, and using probing questions to encourage the interviewee to provide detailed information. The data collection for the qualitative part was carried out in the health training institutions from January to March 2015.

3.8 Quantitative study

The data collection process for the quantitative phase started three months after the qualitative one had ended. This allowed the researcher to analyse the data to get the critical themes for the quantitative phase. It started from July to August 2015 with official communication sent to each participant of the survey sample, containing a letter of recruitment and informed consent. The letter of informed consent specified the following assurances: responses were confidential, no risks or benefits of participation were anticipated, and initial and continued participation in the survey was voluntary. For the quantitative segment of the research, the researcher used a self-developed survey questionnaires. The questionnaire was a cross-sectional survey developed to collect data at one point in time selected to represent the larger population of health tutors in Ghana. The survey instrument was developed based on the outcome of the focus group discussions, the in-depth interviews with health tutors who had left the teaching field, and in-depth interviews with selected principals. Unlike the qualitative study that targeted a small sample of respondents, this section of the study used Krejcie and Morgan's (1970) formula for sample size calculation to target a minimum of 302 respondents to the survey instruments out of the research population of 1,400 tutors. The use of a large sample size confirmed Creswell and Plano Clark's (2018). The assertion that a survey was an appropriate tool for collecting information from a large sample.

3.9 Instrumentation and Data Collection Procedures

Focus group discussions. The first instrument developed was semi-structured open-ended questions for the focus group discussion. The questions were designed to engender group discussions and conceptualization of the concepts of motivation, retention, and equity from the perspectives of public health institution training tutors. The focus group discussion protocol started with questions on background information about participants. Other discussion

questions included how tutors were motivated for tutorship, perspectives of participants on workplace motivation factors, and participants' perspectives on workplace retention factors and issues of equity.

The focus group discussions were conducted in five selected training institutions in the rural north and five in the urban south. The rural northern institutions were Health Assistants Training School in Kpembu, Health Assistants Training School in Nalerigu, Health Assistants Training School in Bole, Health Assistants Training School in Yendi, and Health Assistants Training School in Damongo. The southern urban health training institutions were Korle-Bu Nursing Training College, Korle-Bu Midwifery Training College, Okomfo Anotie Nurses Training College, Okomfo Anotie Midwifery Training College, and Ridge Anaesthesia Training College. The staff list from the Input Personnel Processing Data Office of the Ministry of Health was used to purposively select ten (10) tutors from each institution to form the focus group.

Besides the purposive sampling technique used, the criterion sampling technique was also deployed in selecting the ten focus group participants. The first criteria were that the tutors should have served a minimum of 5 years in the position as a tutor. Secondly, the tutors were structured by age groups 18 to 39 years and 40 to 60 years. Depending on the age group category that had a more significant number of tutors, that was the age group from which participants were randomly selected to participate in the focus group discussion. In the north, Kintampo and Nalerigu had more tutors in the age group of 40 to 60 years and therefore had their focus group members drawn from that age group. In the south, Korle Bu nurses training college and Okomfo Anokye nurses training college had more tutors in the age bracket of 40 to 60, and tutors from this age group were therefore sampled to participate in the focus group discussions. In the rest of the six institutions whose tutors participated in the focus group discussions, participants were randomly selected from the age 18 to 39 bracket. The FGD guide

had four sections. The first section (section A) covered a brief but detailed introduction of all the participants in the focus group, their family and educational background, work profile, and what motivated them into tutorship. Each tutor was given free time to introduce themselves and give the above details, as stated in section A of the guide. The focus group discussion was broken down into three sections of 90 minutes per section. Section “A” took two sections of 90 minutes to be completed. After every 90 minutes, participants were given a snack and a short break to stretch themselves a little. On average, each tutor used 15 minutes for the self-introduction, and they were not interrupted but allowed to talk freely. The other sections, which required the last 90 minutes, examined workplace motivation, retention factors, and equity at the workplace.

In-depth interviews of tutors. There was an in-depth interview for tutors who left the teaching field. The interview protocol contained semi-structured open-ended questions designed to shed light on participants' experiences and perspectives with workplace motivation, retention, and equity. The interview protocol had questions on background demographic information about participants, reasons for choosing to stay or leave their institution.

The researcher used the Input Personnel Processing Data obtained from the Ministry of Health to identify those who have left the teaching field. The researcher contacted their colleagues in the institutions they went to collect their contact phone numbers. In all, the researcher was able to interview in rural north five tutors who were no longer in the teaching field. Five former tutors who were no longer working with the health training institutions were also contacted in the urban south and interviewed.

Key informant interviews for Principals. There was a critical informant interview for principals who have been at that position for 20 years and above. These principals were categorized as critical informants due to their wealth of knowledge of running health training institutions in Ghana. An interview protocol contained semi-structured open-ended questions

was used for this data collection section. The questions were designed to shed light on the experiences and perspectives of the principals with workplace motivation, retention, and equity.

Five principals from the rural north and five principals from the urban south from the health training institutions listed below were interviewed. The rural northern institutions were Health Assistants Training School in Kpembu, Health Assistants Training School in Nalerigu, Health Assistants Training School in Bole, Health Assistants Training School in Yendi, and Health Assistants Training School in Damongo. The southern urban health training institutions were Korle-Bu Nursing Training College, Korle-Bu Midwifery Training College, Okomfo Anotie Nurses Training College, Okomfo Anotie Midwifery Training College, and Ridge Anaesthesia Training College.

For the key informant interviews of the Principals, two Information Communication Technology (ICT) tutors, one from a rural-based health training institution and the other one from urban-based health training institutions, were recruited because of their skills in research work and were trained as research assistants to assist the researcher in the data collection process. The research assistants were employed because the Principals' answers to the questions during the pilot stage were initially influenced by the presence of the researcher, who was the head of the health training institutions in Ghana at the time of data collection (Appendix 5, appointment letter of the researcher as the head of the training institutions in Ghana). Culturally subordinates will give an excellent response to superiors when they are asked questions concerning their work or social life, so principals gave positive answers to please the researcher because the researcher was their head and hence could affect the outcome of the research. There was, therefore, the need to use research assistants for this aspect of the study. The two research assistants were chosen because of the vast geographical distance between the two regions and transport difficulties. Full responsibility for data quality assurance (DQA) and

ownership of the data rested with the researcher. To guarantee the quality of data collected, the research assistants were trained on the data collection tool and how to go about collecting the data. The researcher took them to the nearest school for practice, and corrections were made during practice to ensure uniformity between the data collectors and to ensure that the required interpretation of the questionnaire was adhered to. Data collected by the research assistants were validated daily, and in some cases, follow up was made to verify the authenticity of the data. Raved (2011) described validity as the “extent to which a test measures what it is supposed to measure and the appropriateness of the ways it is used and interpreted” (p.203). Apart from the key informant interview carried out by the research assistants, the other in-depth interviews with past health tutors were conducted by the researcher, since past tutors no longer owed any allegiance to the head of training and were, therefore, free to discuss the reasons why they had left the health training institutions.

The survey. The survey instrument, developed based on the qualitative study, was used to collect quantitative data on the research topic. This is to help use the results from the survey to validate findings from the qualitative study and vice versa for the quantitative study results. The survey had six sections. The first section identified the health tutor, his school, and his location. The second section looked at the staff information in terms of the age, educational qualification, etc. their section of the tool looked at tutors experiences with students and colleagues at the work side, the fourth section looked at staff incentives and capacity challenges at the work side, the fifth section looked at staff motivation, and retention and the last section looked at equity in terms of work side.

3.10 Pilot Testing

All research instruments used for the study were pilot tested. The focus group discussion protocol, the in-depth interview protocol for tutors who were no longer in the teaching field,

the interview protocol for health training institution principals, and the survey questionnaire for the quantitative studies were all pilot tested on various tutors and the principals of Sefwi Wiawso Nurses and Midwifery Training Colleges which is situated in a rural locality, and Pantang Nurses and Midwifery Training Colleges which is located in the urban area of Greater Accra region. The research instruments were piloted twice to increase reliability. Feedback from the first pilot was incorporated into the final instruments that were used for the study.

3.11 Data Analysis

Qualitative data. According to Creswell (2014), exploratory sequential mixed methods study requires that the researcher analyses the data collected from the exploratory qualitative first and use the findings to build the quantitative research instruments. The researcher combined the results of the focus group discussions, in-depth interviews with health tutors who had left the teaching field, and in-depth interviews with selected principals. They have been working in the health training sector for over 25 years to design the quantitative survey instrument administered to 329 health tutors in the urban south and rural north of Ghana.

According to Gläser and Laudel (2013), qualitative data analysis links the data collected with the research questions. The research questions for the exploratory qualitative segment of this study were:

1. What are the factors that motivate the tutors of public health training institutions to stay at their posts in a rural or urban area of Ghana?
2. How equitable do tutors bring the inputs to public health training institutions and the outcomes they receive in a rural or urban area of Ghana?

The first step in the analysis process was to transcribe all the responses from the focus group discussions, the in-depth interviews with health tutors who had left the teaching field, and interviews with principals who have been in the health training field for over 25 years. After

the transcriptions, the data was then sorted and categorized under themes that emerged several times in the data. The themes were then linked to motivation, retention, and equity, which were the three concepts that were being explored.

3.12 Quantitative data

The quantitative data were analysed using both SPSS and STATA software (version 12.0). As part of the data analysis and presentation of results, descriptive statistics were employed to ascertain the frequencies, percentages, and means of key socio-demographic variables. The independent student t-test and the Wilcoxon rank-sum test were also used to test for mean differences and rank-sum differences in responses. The Spearman rank-order correlation test was used to test for the association between motivation and institutional factors. Chi-square (χ^2) analysis was used to test for differences between variables of interest.

Subsequently, regression analysis was used for multivariate consideration of the determinants of staff motivation and retention among health tutors. The primary outcome variables of interest in the regression were motivation and the key retention factors of respondents. The explanatory variables of interest were the location of health training institutions, tutors' educational qualifications, and tutors' gender. Control variables included marital status, years of work experience, and religious affiliation. Multicollinearity diagnostics were performed to isolate explanatory variables with variance inflation factors (VIFs) above the 10.0 rule of thumb (Tabachnick and Fidell, 2001). The regression is modelled below:

$$Ology(y) = X1\beta1 + X2\beta2 + X3\beta3 + X4\beta4 + \dots + \varepsilon$$

Where:

Ology(y) = dependent variable of interest

$X^1 \dots X^4$ = Independent variables

$\beta1 \dots \beta4$ = Coefficients

ε = Error term.

3.13 Data Interpretation

Results of the qualitative data were first summarized into major findings, and how these findings answered the specific research questions. The findings were then used to guide the design of the survey questionnaire. The researcher used the quotes, codes, and themes from the qualitative data analysis to develop a culture-specific survey instrument that focused on the meaning of motivation, retention, and equity from the health tutors' perspectives (Creswell, 2014). The quotes from the qualitative analysis were used to write the survey items, and the codes were used to develop the variables that group the items, and the themes were used to group the codes into measurement scales (Creswell, 2014).

Interpretation of the quantitatively analysed data involved summarizing the major quantitative results generated from the SPSS and STATA analyses and determining how these interpretations answered the mixed methods research question. The results were then compared with other explanations in other empirical and theoretical literature on the subject matter.

3.14 Researcher Positionality

The role of the researcher was to take full control of the research from the conceptual stage of the study to the final thesis and its defense. The researcher was responsible for the planning and implementation of the investigation, including monitoring the research assistants. The researcher also took full responsibility for all the ethical requirements of Queen Margaret University and the Ministry of Health in Ghana. The researcher's interest in the topic stems from my work as the immediate past executive secretary of the health training institutions in Ghana. Health tutor motivation and retention were a critical determinant of the quality of teaching and learning.

Furthermore, the researcher's life experience as a health tutor revealed much about the need for well-motivated tutors and their retention, especially in schools located in the deprived or rural areas. As a health tutor and the immediate head of the training institutions, the researcher is personally related to the topic. The researcher has been involved in the use of data for decision-making and program evaluation, and knows the value of bracketing, triangulating, checking, and validating data. The researcher 'bracketed' as much as possible, personal experiences to avoid influencing the research findings. The researcher recognized existing biases and remained transparent, as recommended by Patton, (2015) and Creswell, (2014).

3.15 Reflexivity

Reflexivity is a continuous process whereby researchers reflect on their preconceived values. Those of the research participants, such as reflecting on how data collected will be influenced by how participants perceived the researcher Parahoo (2014). Holloway and Wheeler, (2002) further asserted that researchers should reflect on their actions, feelings, and conflicts experienced during research. To achieve the credibility of the study, the researcher should adopt a self-critical approach to the study, the participants, their role, relationships, and assumptions. Reflexivity is not easy to carry out, as it is challenging to stand back and examine the effects of one's preconceptions. The researcher consistently validated data by going back to the participants to confirm the interpretation. Validation of data provided an opportunity for clarification and for researchers to recognize their prejudices (Parahoo, 2014).

In this study, the researcher wrote down any feelings, preconceptions, conflicts, and assumptions about the study. This enabled self-monitoring to prevent bias and increase objectivity. In terms of personal reflexivity in this study, the researcher's previous work as a tutor and the head of the training institution might have affected the critical reflection of the

factors affecting motivation and retention of health tutors. This was dealt with through a continuous and sustained awareness of this influence during the research process. The researcher's self-consciousness about his background, experiences, values, and belief systems helped him to reduce bias arising from this, which could have a potential impact on the entire research process.

3.16 Chapter Summary

The purpose of this mixed methods study was to examine how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana. The study specifically used the exploratory sequential mixed methods design, where qualitative research was first conducted. The results were used to guide the formulation of a survey questionnaire for the quantitative segment of the study. The study adopted the exploratory sequential mixed methods study to adequately the following specific research questions

1. What are the factors that motivate the tutors of public health training institutions to stay at their posts in a rural or urban area of Ghana?
2. How equitable do tutors bring the inputs to public health training institutions and the outcomes they receive in a rural or urban area of Ghana?

To address the first two qualitative research questions, focus group discussions and in-depth interviews were conducted for tutors and principals in the selected rural north and urban south health institutions. The results of the qualitative study were used to design quantitative research using survey instruments. A total of 329 tutors in the rural north and urban south health institutions were randomly selected to participate in this segment of the study. The results of the quantitative research were analysed using SPSS and STATA software. The findings of the quantitative section of the study were used to answer the final research question: To what extent and in what ways does the quantitative results confirm the qualitative data that tutors from

urban public health training institutions are better motivated, equitably resourced, and retained at their posts than their counterparts in the rural areas?

CHAPTER 4

RESULTS

4.1 Introduction

This chapter presents the qualitative and quantitative results of the study related to health tutors motivation and retention in Ghana. The researchers used both qualitative and quantitative methods to complement each other. The qualitative research was conducted to follow up on findings from quantitative data and to help interpret the figures from the survey. There are two main sections. Section 1 looks at the demographic details of the participants in the study. The second section looks at the background conditions and circumstances that lead to individuals making choices regarding working as health tutors, using case studies of four participating individuals.

4.2 Demographic characteristics of respondents for the qualitative study

For the qualitative part of the study, one hundred health tutors were shortlisted for the focus group discussion. However, five of the tutors opted not to take part, two gave reasons for not feeling well, and three others cited personal reasons.

Table 11: Demographic characteristics of respondents for the quantitative study

Focus group discussion			In-depth interview			Key informant interview		
Details	No	%	Details	No	%	Details	No	%
Age			Age			Age		
20-29	35	35	20-29	1	20	20-29	-	
30-39	40	40	30-39	3	60	30-39	-	
40-49	15	15	40-49	1	20	40-49	1	20
50-59	10	10	50-59	-	-	50-59	4	80

Total	95		Total	5	100	Total	5	100
Gender			Gender			Gender		
Female	58	61	Female	3	60	Female	4	80
Male	37	39	Male	2	40	Male	1	20
Total	95	100	Total	5	100		5	100
Education			Education			Education		
Certificate	-		Certificate	-		Certificate	-	
Diploma	5		Diploma	-		Diploma	-	
Degree	62		Degree	3		Degree	-	
Master	26		Master	1		Master	5	
PhD	2		PhD	1		PhD	-	
Marital Status			Marital Status			Marital Status		
Married	46	48	Married	5	100	Married	5	100
Not married	33	35	Not married	-	-	Not married	-	-
Divorced/ Separated	14	15	Divorced/Se parated	-	-	Divorced/S eparated	-	-
Widowed	2	2	Widowed	-	-	Widowed	-	-
Religion			Religion			Religion		
Christian	73	77	Christian	4	80	Christian	4	80
Muslim	19	20	Muslim	1	20	Muslim	1	20

Traditionalist	3	3	Traditionalist	-	-	Traditionalist	-	-
Total	95	100	Total	5	100	Total	5	100
Location			Location			Location		
Urban	50	53	Urban	3	60	Urban	3	60
Rural	45	47	Rural	2	40	Rural	2	40

Source: Survey, 2016.

The quantitative part had 329 participants. However, some of them decided not to answer some questions. Below are some of their demographic details.

Table 12: Gender of respondents

	Frequency	Percent
Male	189	57.4
Female	140	42.6
Total	329	100.0

Source: Survey, 2016.

Table 13: Marital status of the respondent

	Frequency	Percent
Never Married	63	19.1
Married	241	73.3
Divorced	2	.6
Separated	14	4.3
Living Together	7	2.1

No answer	2	.6
Total	329	100.0

Source: Survey, 2016.

Table 14: Religion of respondents

	Frequency	Percent
Christian	165	50.2
Muslim	70	21.3
Traditionalist	59	17.9
None (atheist)	6	1.8
Other	2	.6
No answer	27	8.2
Total	329	100.0

Source: Survey, 2016.

Table 15: Educational qualification

	Frequency	Percent
Certificate	3	.9
Diploma	31	9.4
First Degree	149	45.3
Second Degree	133	40.4
PhD	13	4.0
Total	329	100.0

Source: Survey, 2016.

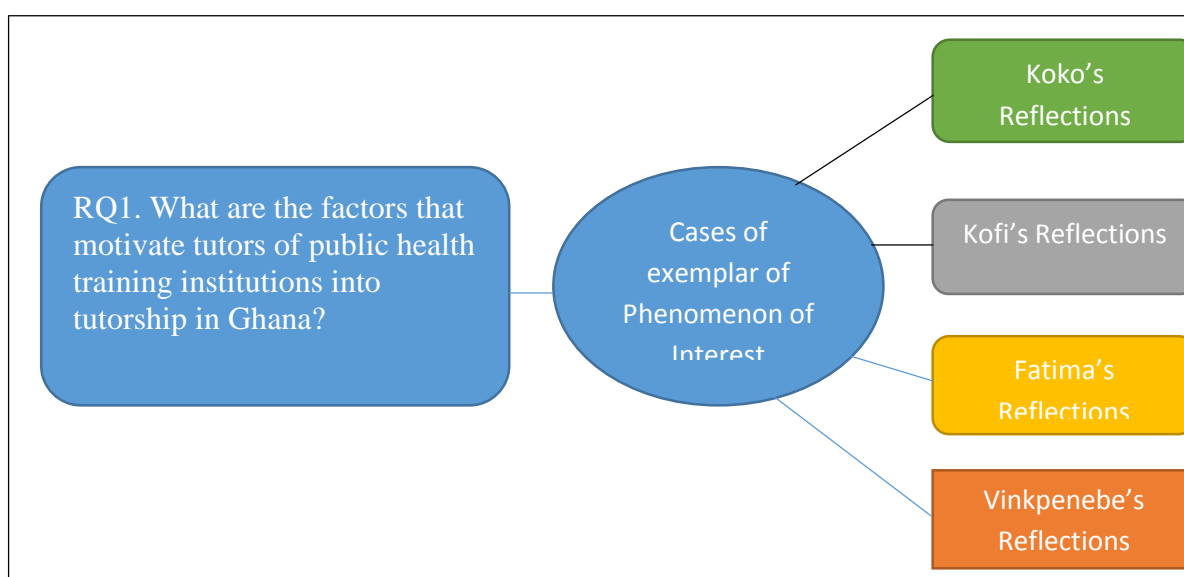
However, all the participants (qualitative and quantitative) were the staff of the Ministry of Health Training Institutions. The minimum number of years of tutorship for the participants in quantitative and qualitative study was a 1-year experience. In this research, nursing is divided into general nursing and midwifery. All other professions apart from nursing, who teach were classified as allied health based on the classification from the health training institutions unit/secretariat of the Ministry of Health- Ghana.

4.3 Case studies of health tutors

Case study research is deemed suitable when the proposed research addresses a contemporary phenomenon, which the researcher has no control over. The research is exploratory mainly and discusses the how and why questions (Benbasat, et al., 1987; Darke et al., 1998; Yin, 1994). Most case studies seek to elucidate the features of a broader population. They are about something more significant than the case itself, even if the resulting generalization is issued tentatively (Gerring, 2004).

This section presents four cases as exemplars of the phenomenon of interest regarding how to motivate the health tutors to stay at the post in the rural or urban area and why they choose a rural or urban area to teach. As noted by Patton (2015), any good case can be chosen as an exemplar of a phenomenon of interest where the case offers insights into the phenomenon and stand alone as important. The section will present a brief overview of the case study method of some health tutors, compare it with quantitative research findings, and study the merits and demerits.

Figure 6 : Cases of Exemplar of Phenomenon of Interest related to Research Question 1.



Source: Survey, 2016.

The stories of Koko, Kofi, Fatima, and Vinkpenebe extracted from the first section of the focus group discussion will be presented. The first part of the guide asked participants to give a brief but detailed introduction of themselves in terms of their family background, educational, and the reasons for opting to be a tutor in the health training institution. This is to see if the background of the health tutors has a relationship with their motivation to teach and their retention at their current post. The four stories were selected because they were typical of the others. Two were selected from the rural part while the other two were from the urban area. The four were selected based on the research questions, the in-depth background to their story, and some issues that were uncovered as key to health tutors motivation.

The four covered all the key issues that came out from the other participants. Their stories were taken and analysed from section A, questions 1 – 5 of the focus group discussion. In the next section, we explored how the family, the environment, cultural beliefs, and the socio-economic orientation of an individual shape their interest in a profession. Some might enter a job because of money, others because of family pressure, and others for various reasons. The stories here

will look at some health tutors background conditions and circumstances that lead to individuals choosing to become health tutors and their daily roles.

4.3.1 Koko's reflection (Urban nurse, U1).

Koko, a 48-year-old health worker, who works in the capital, Accra, and has lived there almost all her life, traveling only to Kumasi, Cape Coast, Koforidua, and Sekondi. Considering all these are large urban centres in Ghana, one can conclude that she has lived a city life per where she lives and places visited. The visits to these places were either for training, workshops, vacation, or family visit. Koko has never experienced, nor wished to experience the rural life because social amenities in rural areas lack. She says; Imagine working in a place like the north where there are no excellent international schools, no recreational areas, and most importantly, an excellent private hospital that can take care of you and your family when you are sick. The place is not as big as Accra, where you have shopping malls to visit. I prefer to stay here or resign when being forced to go to some places.

She is the first child in her family to go to college. During middle school, she knew she wanted to go to nursing college rather than university. Her choice of nursing training college was the fact that her parents could not afford to pay the university tuition fees, and she had to compete with others for a job. She believed in the notion that you must know someone before you get a good job after university, so she preferred the nursing training college, which did away with the 'whom you know syndrome'. In the nursing training college, she did not pay fees, she was given students allowance and automatic employment after school. She knew that she needed to get a job on graduation to enable her to save some money for further studies because her parents could not afford those.

After completing nursing training in the early 1970s, she was employed in a hospital in Accra. After working in the hospital for five years, Koko decided to return to the classroom to deepen

the clinical knowledge she had acquired. For Koko joining tutorship was the only opportunity to get a free sponsorship to pursue a degree in health science, which was offered to all tutors with a diploma to upgrade to a degree. Even though Koko became a tutor, she continues to work at the hospital by sending students for clinical practices. She takes part in the clinical practices in order not to forget her skills. For Koko, Wednesdays are free days, she does not have any lessons to teach, so she works part-time as a nurse in a private hospital to earn additional money. Her school has only two programs namely Nursing and Midwifery, with a total population of 850 students and 76 health tutors to teach 12 subjects per the semester. Per her view, the workload was not much as compared to some schools that had few health tutors but more students. This situation allowed some teachers to only share topics among themselves to teach for the whole semester but not teaching an entire subject like anatomy, research, and so forth.

Depending on the internal politics in terms of ‘whom you know’, it is possible to have two days off per week for the whole year, to pursue some courses. However, if you do not know anyone, your chances are limited. According to Koko, her former tutors and friends were very proud when she got the tutorship appointments because she was the first among her class to be considered for a tutorship position. Koko said, *“I had always wanted to teach, I want others to learn from me”*. Further, she emphasizes that she did not want to spend the rest of her working life in the hospital. Koko also mentioned that the Ministry of Health was quite influential in helping her realize her full potential. The Ministry was a source of encouragement and often provided scholarship information and wrote recommendation letters for her. As a result, she was able to obtain scholarships for her first and second degrees.

According to Koko, her students regarded her as a good teacher. It was these experiences, accompanied by the collegial respect she received, that led Koko to the decision to remain in tutorship; Working at the hospital some years back and going to school has developed my skills

to become a better teacher. I wouldn't have had that scholarship to pursue further studies if I had not opted to be a tutor, So, I want to give back to society what society has given me by teaching others to become professionals. I love teaching.

Contemplating the future, Koko discussed how she would like to continue in the classroom for three to four more years, after which she would like to attend graduate school and earn a PhD. or second Master's degree so that she can move into the school's administration. In her opinion, working as a principal would allow her to give better treatment to students and staff and to implement her vision of encouraging others to teach and to remain in teaching.

4.3.2 Kofi's reflection (Urban nurse, U2).

Kofi is a 32-year-old man and a teacher in Anatomy and Physiology. He has been in tutorship for ten years. His parents instilled in him the importance of school and receiving an education. Reminiscing, Kofi realized that he was exposed to a tutorship at a very young age. His father was a headteacher in one of the schools in the south, so his father took him to school every day. On their way to school, Kofi's father advised him that education was the key to success. Coming from a low-income family, the only way to develop yourself and your family is through education. Kofi remembered joining his father to participate in church talk shows, health education, and community sanitation programs. Kofi fondly recalls his mother telling him once that he was a peculiar child because instead of going out to play football, as most of his male peers in the area did, he preferred to read his books and asked many probing questions. This time was a significant part of Kofi's life because it was during this period that he came to understand what career he would pursue. He loved science and was a curious child, trying to determine how things were created or how they worked. In school, even though he did not have any hands-on science laboratories, he enjoyed science very much.

After completing senior secondary school, he wanted to go to the teacher training school to teach. Still, he also remembered how his mother died due to the poor attitude of health workers, so he joined the nursing training school to provide better quality health care services. He completed with distinction and was employed in one of the hospitals in the city. After working for three years in the hospital, he felt his dream of becoming a tutorship was at risk of fading and so decided to apply to join health tutorship.

As a health tutor, Kofi reports to school between 7:30 am, and 9.00 am, depending on the traffic situation, and finishes at 2:30 pm to do some part-time teaching in a private nursing school. Fortunately, he does not hold any official position or handle any extra-curriculum programs, so he has enough time for his studies at home and in the private nursing school to teach. He has shown his students not only the content necessary for them to pass the final licensing exams of the nurses and midwives council, but also life on the clinical side, which is very necessary after school, during practice. A happy day in his life as a tutor is when he can have a healthy classroom interaction with his students, with most of them participating in discussions and answering questions. He expects that at the end of the day, his students should apply what they have learned in the classroom to their daily lives. I guess what makes me happy and fulfilled as tutors are that at the end of each year, I got students coming to me to thank me and tell me that they have passed their licensure examination.

Kofi's reports that students have been extremely grateful to him for the proper lessons bestowed on them. For him, students success is the most rewarding aspect of his tutorship experience. According to Kofi; My guilty conscience does not serve me right. I wish some tutors can be transferred to the north to support our colleagues, but I don't personally want to go to the north. The weather is scorching, no proper social amenities, and above all, it's very far to Accra where all the opportunities are.

When he compares himself to the others elsewhere, especially those in the north where there is a shortage of teachers, he feels terrible for teaching fewer hours and will need more teaching hours. Kofi's view that there was the need to transfer tutors to the north because of the lack of tutors correlates with the Ministry of Health training institutions concern regarding the high tutor-to-student ratio in the north compared to the south. Kofi's statement is also supported by the survey results that showed most of the tutors (73.3%) were interested in the urban schools in the south. The tutors did not wish to move to the north, which had most of the schools located predominantly in the rural area and lacked social amenities and opportunities for progression. Kofi's ultimate goal is to help students who join the nursing profession to love the job. He reports his driving motivation to continue tutorship and to promote quality of nursing practice in Ghana, and to become a principal one day.

4.3.3 Fatima's reflections (Rural nurse, R1).

Fatima is a health tutor, born and bred in the northern part of Ghana, considered rural. Fatima is a nursing tutor and a Muslim, she used to follow her mother to the farm, and from the farm to the kitchen, which was considered a special place for the woman and most women were not allowed to go to school. She once had an opportunity to go to the village antenatal clinic with her mother when she delivered her fourth child. It was there that Fatima admired the uniform of the community health worker and the advice that a young community health nurse gave to her mother, saying to her mother, 'Please mom, can you talk to dad, I want to be like this woman. Kindly take me to school'.

Her mother pleaded with her husband, and although a Muslim, Fatima was allowed to go to the local Roman Catholic (RC) primary school. Fatima became familiar with the nuns work and their reasons for offering services that they do. The nuns and people in the religious community want to reach out to as many people as possible, regardless of the person's culture, religion,

and background. Fatima quickly learned that she, too, would like to be someone who can reach out and help others. She took her studies seriously and had in mind that ‘knowledge is power’. As a result, it was not uncommon to find Fatima reading books in the house. Fatima realized that early on in her childhood, she dreamed of becoming a tutor. Though her father did encourage her to become a doctor, Fatima believes the reasons for her parents preferring a medical profession to tutorship was because of social status and money. Teaching is considered a profession with a lower level of status in Ghana. However, Fatima had decided to become a health tutor to advise and encourage others like the community health worker she met at the antenatal clinic. Therefore, she went to university to pursue nursing instead of medicine because she could not make the grade for medicine. After university, Fatima did not go to the ward but went straight to join the Ministry of Health as a tutor. In the beginning, Fatima was faced with several challenges. Firstly, her colleague tutors and the principal called her by name ‘Direct’ which means she did not go through the formal nursing training school of the Ministry of Health but rather the Ministry of Education direct degree program.

Some health workers perceived that direct university graduates knew much theory but had less clinical practice. The principal of the school did not want Fatima to teach a nursing course because she was not a graduate of the Ministry of Health training school. Still, because the school had three (3) different programs (Nurse assistant clinical, general nursing, and midwifery), with a population of 2800 students with only 18 teachers, the principal had no option other than to shift some of the pressure from the limited tutors onto Fatima. She taught four subjects per semester and did 10 hours a day teaching. Aside from teaching, Fatima was the tutor in charge of catering. Her responsibility was to ensure that the students food was sufficient, tasty, and hygienic and delivered on time. She was also the clinical coordinator and therefore was responsible for ensuring that clinical sites were ready for students, facilitating a successful clinical experience without any hitches. Because of the high workload, she

sometimes had to teach after 6 pm or some time on Saturdays to help students prepare for their licensing exams.

The licensing exam is an exam set by the Nurses and Midwives Council of Ghana, based on a standard curriculum. Therefore, regardless of the tutor to student ratio, students in every school must sit and pass the exam before they could practice. According to Fatima, each teacher in the school had to perform two or three roles apart from the teaching. Some of these roles included procurement, academic head, head of the library, et cetera. Due to her interest in the profession, she never gave up despite the heavy workload. she continued teaching and contributed significantly during staff meetings. She also joined students and staff in clinical practice to learn. After three years of dedicated service, learning, and obedience, her first cohort of 500 students who took part in the licensing exams had 480 students passing the exams, and they were among the top five out of 96 schools. The Principal, therefore, had trust in her, and she was thoroughly inculcated into tutorship and given more responsibilities. She said: I have always felt useful in this environment despite a few challenges; because i've seen that i can contribute significantly to the students. It has been delightful, adorable being able to teach and help my quota to national development.

When questioned about when her free days are, Fatima said she does not have open days except on Fridays between 1-2 pm when she goes to the mosque to pray for long life, strength, and Allah's blessing. Fatima's story from this research further supports the idea that personal characteristics of the health worker, such as place of origin (rural or urban), gender, ethnicity, age, personal values, and beliefs, have a significant impact on their employment decision. It should be noted that the way these factors influence health professionals' decisions might vary according to the individual's background and stage of the career (Lehman et al., 2008). Evidence demonstrates that rural upbringing increases rural practice (Lehmann et al., 2008; Dussault and Franceschini, 2006). Fatima's entire life has been rural-based, so she enjoyed

working in the rural area, just as Koko and Kofi lived all their life in the city and therefore did not want to be transferred to the rural north. Fatima wishes to see a future of being rewarded as the overall best health tutor in Ghana or given the position of principal due to hard work and sacrifice. She mentioned that she would always like to continue teaching till death do her part with tutorship.

4.3.4 Vinkpenebes reflections (Rural nurse, R2).

Vinkpenebe means my enemies will be disappointed. Most Ghanaian names have meanings, and it is believed to shape the lives of the individual and given based on situations prevailing during the birth of the child. From a typical rural part of Ghana, Vinkpenebe mentioned that his parents had minimal education and were from the impoverished family background. His father felt that the only way his enemies would be disappointed was to ensure that his son Vinkpenebe would get a better education, to lift the family out of poverty for their enemies to be ashamed. With his father having made it only to the middle school, he was supportive of Vinkpenebe's education and encouraged him to aim high in life. He wanted the name to follow him and gave him all his blessings. Vinkpenebe reminisces; I didn't know anything about going to college, i didn't realize that there was an allowance, i didn't know anything but my dad. I don't know how he learned about this nursing programme, went and applied for me and got the admission to go to nursing college. As a middle school leaver, my father could actively read and write. I went to the nursing training college and graduated from college with excellent grades, so I was asked to stay in nursing school as a teaching assistant. According to Vinkpenebe, although his certificate does not qualify him to teach as a full tutor, he was allocated three subjects for teaching without the support of any superior because of the shortage of staff in their school. Apart from teaching, he doubles up as the tutor in charge of sports, the head of academics because he was very good at the computer compared to the other colleagues,

and the head of procurement since the school did not have the full staff to complement administration. Owing to the additional roles, he travels to do purchasing for the school, enters all the marks of the various tutors into excel spreadsheets, and supports student discipline.

To Vinkpenebe, one of the advantages of being in the village is getting free land and labour to the farm. Mostly he takes some of the students to work on his farm in the morning, and later, some of the students help him with cooking, washing, and other household duties. To him, these are some of the benefits a tutor derives, mainly when you are in the rural area and your family does not stay with you. According to Vinkpenebe; I am very much happy working in the village because the cost of living is meagre, you do not need transport, and you do not pay a considerable price for accommodation. The teachers work as a team, knowing that the faith of their students depends on them. Our biggest strength as tutors in this school is that we have accepted to teach in this rural area not because of anything, but because we to teach, and the students respect us.

As will be shown in chapter five, the views of Vinkpenebe, who lives in the rural area, also tally with the survey results on the role of intrinsic rewards in motivating staff to work in rural areas. Vinkpenebe feels the cost of living in a rural area is meagre. Unlike the urban area, you do not need a vehicle to get to school. You walk, which saves you money. The comment correlates with the fact that job mobility for women appears to be more likely to be influenced by family considerations. In contrast, for men, mobility is guided more strongly by economic reasons (WHO, 2013).

After working for some time, Vinkpenebe said he remembered his father's advice and the reason for his name Vinkpenebe, so he vowed to live up to the expectation of his father by continuing his education. Due to his hard work, academic performance, and respect for his superiors, he was sponsored to continue his diploma and degree level. 'My childhood dream was to become a lecturer with a PhD because that is the highest degree, which will see my

father very happy, and my enemies ashamed'. He explained that his name, father's inspiration, and blessing left lasting impressions on him and influenced him to become a tutor. He was coming from a village where only two people had obtained a PhD. Vinkpenebe wants to be the third person to acquire a PhD and one day become the principal of a college.

4.4 Chapter Summary

The chapter identified five significant findings in analysing the context and background of the health tutors from the case studies discussed. The first finding was that health tutors reasons for entering the teaching profession vary depending on their backgrounds, including economic, emotional, and social situations at the time of deciding. This study extends Smulyan's (2004) assertion, which indicates that researchers often overlook teachers class and the cultural background even though these factors inform teachers decisions to select teaching as a profession.

The second finding was that some health tutors committed to making a positive difference in students tend to remain where they started teaching, regardless of school conditions. Thirdly, health tutors, who came from communities similar to that of the students, tended to relate better to students, had a caring understanding of their needs, and expressed a more significant commitment to protecting the rights of all students to education. This confirms earlier studies that examined entry reasons to the teaching black women teachers (Dixson & Dingus, 2008), indicating that ethnicity and cultural community backgrounds are decisive factors when selecting the teaching profession.

The fourth finding was that school administrators might have the answer to solving the low retention among health tutors if they take into consideration what motivates teachers to enter the profession, identify, and address teachers needs early in their career. Many of the respondents in this study articulated strong feelings of frustration with the unreasonable

demands of the schools over-loading teachers with extra work, which included the weekends. This finding builds on the assertion made by Kersaint et al. (2006) of the importance of identifying factors that contribute negatively to teachers' decisions to either remain to teach or leave teaching altogether. Finally, health tutors regard the school environment support systems, including colleague teachers and mentors and campus-level administrators, remarkable in deciding to stay in a school. This supports Boyd et al. (2010) findings indicating that administrator support emerges as a strong predictor in teachers decisions to remain to teach or transferring to another school.

CHAPTER 5

HEALTH TUTOR'S MOTIVATION IN THE GHANAIAN CONTEXT

5.1 Introduction

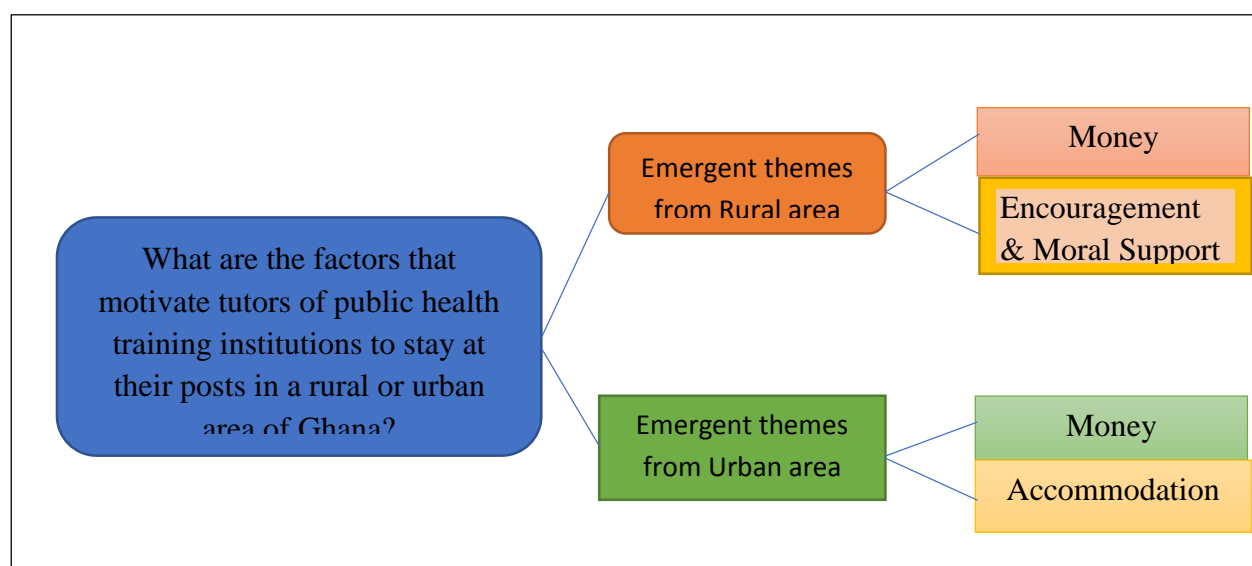
Once again, the purpose of this study was to examine how tutors of public health training institutions are motivated and retained at their posts in rural or urban areas of Ghana. An exploratory sequential design was used first to explore qualitatively to develop a context-specific and sensitive quantitative survey instrument to be administered to a large sample of tutors in public health institutions in Ghana. I sought to answer one overarching research question and three two theory-driven questions, and one combined mixed methods research question. The overarching research question was: How are the tutors of public health training institutions motivated and retained at their posts in a rural or urban area of Ghana? And the specific research questions were:

1. What are the factors that motivate the tutors of public health training institutions to stay at their posts in a rural or urban area of Ghana?
2. How equitable do tutors bring the inputs to public health training institutions and the outcomes they receive in a rural or urban area of Ghana?
3. To what extent and in what ways does the quantitative results confirm the qualitative data that tutors from urban public health training institutions are better motivated, equitably resourced, and retained at their posts than their counterparts in the rural areas?

This chapter primarily focuses on health tutors motivation. The chapter is divided into three sections. In the first section from survey question E1, tutors were asked to define motivation. Survey question E1 was then followed by survey question E4 and E5 as tutors were asked to do an appraisal of the most significant thing that motivates them based on their socio-demographic characteristics (location, gender, age, religion, marital status). The section that follows is based on equity theory, investigates health tutors perceptions of equity in the

workplace, and their reaction to perceived conditions of equity and inequity in the workplace. Finally, drawing upon survey and data sources (FGD, KII, in-depth interview) responses from earlier sections considered what would be the overall level of motivation for health tutors. The researcher revisited motivation after equity theory because the researcher wanted to find out despite the critical problems identified in the study that affects their motivation and the issues of equity and inequity at the work side, what was their overall level of motivation. Whether they were still very motivated to work or not motivated or what was their state of motivation despite the critical issues discussed on motivation.

Figure 7: Common emergent themes related to Research Question 1.



Source: Survey, 2016.

5.2 Views of participants on motivation

For tutors, motivation proved to be a complex issue affected by many factors. No one factor was seen to guarantee motivation in the absence of other critical factors. Some health tutors take the view that money cannot be used to motivate employees. While this may be true for some employees, for a large percentage of the workforce, money is what is termed motivation at the workplace. To some, however, decent accommodation offered by the workplace may be

considered a key motivator for their retention. It appears essential to distinguish between what health tutors think is motivation and their appraisals of the most significant things to motivate them. These are two distinct things, as one tutor humorously noted; To most of the health tutors here in the focus group discussion section B, question 4, motivation is money, isn't it? However, what will significantly motivate me is different from what will hugely motivate some of you here, although most of us agree motivation is money. So, the most significant thing to motivate me is different from what I think is motivation. I might be motivated by money, but the most considerable something to motivate me now will be a Mercedes Benz car because that is what I fancy, so give me one. I will be very much motivated to serve in any part of the country.

Knowing their orientation as to what they think is motivation and their appraisal of the most significant thing to motivate them will enable policy maker's work towards providing them for the health tutors. It is, therefore, necessary to distinguish between the two things based on the socio-demographic and other factors of the respondents.

Overall, this research is aimed at informing appropriate stakeholders and authorities on empirical bases for policy reforms and interventions to strengthen health training institutions and pre-service education in Ghana and seeks to provide a firm basis for policy discussions on appropriate and effective workplace incentives for health tutors. It is therefore vital to explore the personal views of the tutors as to what they perceive as motivate based on their socio-demographic characteristics and how best they could be retained

5.2.1 Why worker motivation

The first question that arises is, why managers need to motivate employees? (Herzberg, 1959). According to Smith (1994), reflecting on private sector circumstances, staff motivation is crucial to the survival of a company. Amabile (1993) argues that managers and organizational

leaders must learn to understand and deal effectively with their employee's motivation since motivated employees are necessary for organizational success. She also observes that unmotivated employees are likely to expend little effort in their jobs, avoid the workplace as much as possible, exit the organization because of the lack of interest in the organization and produce a low quality of work. In contrast, when employees are motivated, they help organizations survive in rapidly changing workplaces (Lindner, 1998). Lindner suggests that the most complex function of managers is to motivate employees because what motivates employees changes always (Bowen and Radhakrishna, 1991). This section is focused on the individual health tutor and what motivates them at the workplace.

In line with the research objectives, the researcher asked the participants in the FGD section B, question 4, and in the survey, section E questions E1, what they think is motivation. Based on the background information the participants, the researcher differentiated the views of the rural people from the urban as to what motivation is. There was a particular interest in whether there were differences in rural and urban perceptions as to what they define as motivation.

There was no significant difference between urban and rural in terms of definitions of motivation ($X^2 = 9.2$, $p = 0.055$, $DF = 4$), based on a 95% confidence interval. The survey indicated that 49.4% of tutors from urban areas believed that motivation was fundamentally about money, while accommodation was proposed as motivation by 21.3% of respondents. A similar trend was observed for those from rural areas, with money (33.1%), which is the main definition of motivation followed by encouragement and support (28%). This is broadly in line with findings from Sara et al. (2004) regarding the fact that money is an inducement in many circumstances. The same trend was also observed during the focus group discussion as most of the tutors mentioned money as motivation. One tutor from a rural school said: "Motivation, motivation is all money, give us money, and we will be motivated to work hard, without money there is no motivation".

Another tutor from the urban school shared a similar view, “Motivation is to encourage or push someone to be happy to work, and what will push me to work hard is money.” However, in the personal appraisal of motivation, there were differences between urban and rural health tutors. Urban tutors considered accommodation (44.8%) as the most significant to motivate their work, while rural tutors considered money (53.2%) as the most significant motivator.

These findings from the survey concur with themes emerging from the focus group interviews conducted among the tutors. Many of the health tutors in the urban area said that low salaries and high cost of rent forced them to apply for bank loans, as the Ministry of Health and the training institutions do not have loans available for staff to access for rent. A health tutor in the urban area will, in these circumstances, instead be given accommodation as a motivator than money. One of the health tutors in the capital, Accra, reported that she needs to do extra work in addition to her government work to pay her rent; I do not own a house. I am not given an allowance for rent, but I have to pay GH¢2,800.00 per year for rent alone, this does not include, feeding, electricity, and others, I don't know where I can get that money from, which means I have to go in for a bank loan to enable me to pay for my rent. What will make me very happy to work hard or be the most significant thing to motivate me while in the city to remain loyal is to give me a house or free accommodation? ... If I can be provided housing, I will stop crying and complaining about that, but such a thing does not exist in my school (Rural nurse, R4).

Health tutors in the rural areas reported a more positive experience with rents and saw money as the more powerful motivator. Whereas most of the health tutors in the urban area complained about the high rent or lack of rent allowances, most of those in rural areas felt encouraged by the low cost of rent and living expenses in the rural area. One of the tutors in the rural areas said; In choosing what will be the greatest thing to motivate me to work hard and to stay, I prefer money because accommodation is extremely cheap in this village and sometimes you

could even be offered free accommodation by the community so giving me money is essential. (Rural nurse, R3).

From interviews, it was clear that the cost of renting in the rural area was far cheaper than in the urban area. Results from both qualitative and quantitative data supported the finding that – despite defining money as a principle for motivation – in practice, those in rural areas preferred cash as the single most crucial thing to motivate them. In contrast, health tutors in urban areas preferred accommodation.

5.2.2 Motivation and gender.

The researcher performed further analyses to explore the definition of motivation based on gender. It was observed that 37.6% of males defined money as motivation compared to 46.6% of females. The next strongest view as to the definition of motivation was encouragement and moral support (males = 26.3%, females = 22.1%), followed by support for travel (males = 22.0%, females = 16.0%). A Chi-squared analysis suggests that there was a significant association ($X^2 = 7.95$, $p = 0.047$, $df = 3$) between gender and the individual appraisal of motivation. Both males (44.5%) and females (40%) said the money was the greatest thing to motivate them. This was followed by accommodation as the greatest motivator for 21.3% of males and 35.8% of females.

From the focus group discussion, a similar pattern was observed in their appraisal of motivation, as both sexes unanimously agreed that money is the most excellent motivator. Most of the males said having cash in the pocket makes you a man and the head of the family, as money is needed for daily “chop-money” and to energize you. Chop-money in Ghanaian context means regular upkeep money meant for the family. One of the male tutors said; Money is what makes a man be a man when you don’t have money, you are useless before your wife,

and your wife will not respect you because you cannot afford “chop-money” but when you have the money you are recognized as the head of the family (Rural nurse, R6).

Most of the women also said money because a woman cannot always ask for everything from the husband; there are certain things you must buy yourself else your husband will not respect you and will think you are a liability. One of the female tutors said; Nowadays, men look at your pocket before proposing marriage, and they want to know the kind of work you do and how much you earn so that you can support the family, it's not everything that you can ask from your husband, for example, panties, menstrual pads, etc., you need to buy them yourself (Urban nurse, U5, personal communication)

This correlates with the findings of the survey, which ranked money as the highest denominator to motivate both males and females at the workplace and support the fact that money remains, arguably, the most crucial strategy of motivation (Akintoye, 2000).

5.2.3 Age categorization.

For this research, participants were categorized into 20-29, 30-39, 40-49- and 50-59-year groups. There was a significant association ($X^2 = 51.6$, $p = .000$, $df = 12$) in terms of the definition of motivation and age. For the age groups 20-29, 30-39, and 40-49, motivation was defined as money, with 43.2%, 42.2%, and 40.6%, respectively. However, the 50-59 age group (38.5%) considered encouragement and support as their definition of motivation. This supports the findings that adults in the later stages of their careers are less driven by the need to prove themselves through their achievements. Which is generally accompanied by competitive behaviour at work, and that they might be more driven by aspects such as meaningful work, encouragement, and support at the workplace (Tolbert & Moen, 1998). Similar results were observed for the qualitative data as participants age 20-29, 30-39, 40-49 defined motivation as money, and that of 50-59 years said what constitutes motivation was accommodation. One

elder man nearing retirement age of 60 years said; When I was young like the researcher, I used to think of money as motivation. But as time goes on, I started to understand that motivating me is not money, but giving me a house, something I can always remember, a property I can bequeath to my family is what I will say constitute motivation. (Rural nurse, R8)

This contrasted with what one of the participants aged 25 said, 'You cannot define motivation without mentioning money, everything in this world is about money. Motivation to me is money' (Urban Allied, UA1). However, this confirms the survey results in terms of the definition of money and age.

In assessing the various age groups to see if there were differences in terms of their appraisal of motivation, there was a significant association between age groups and what constitutes the greatest motivating factor ($X^2 = 35.4$, $p = 0.0$, $df = 9$). Using the symmetric table from the analysis, the Cramer's V value was 0.000, which signifies a small effect size for the age group and what they perceived as the most significant thing to motivate them.

Age groups 20-29, 30-39, and 40-49 selected money as the most significant thing to motivate them with a percentage of 55.9%, 44.7%, and 63.7%, respectively. However, those within the age group 50-59 said the accommodation was perceived to be the greatest thing that can be used to motivate them (45.7%). This supported the findings from Bellenger, Wilcox, and Ingram (1984), as well as from Kanfer and Ackerman (2000), who reported significant age differences between adults younger and older than 30 years. Kovach (1995) found significant differences between age groups, the under-30 group valued good wages, and from the findings of this research, those within the age group 30 rank money as the most excellent motivator. A similar pattern was observed for the qualitative study, as participants of age 20-29, 30-39 ranked money first in their appraisal, while those between 50-59 ranked accommodation as the first. It was observed that most of the very elderly who were about to go on retirement (between 50-59 years) talked about a befitting retirement package like a house to lay their heads. One of

the most senior health tutors with about three years to go before retirement said; My concern is a decent place to lay my head, I haven't completed my house yet, but I have only some few years to go, what will really make me very happy and motivated me very well is a house for my family when I go on retirement. (Urban Allied, UA2).

In summary, the young and middle age group defines motivation to be money, and in the appraisal, ranked money as the most significant thing to motivate them, while the elderly group nearing retirement age (50-60) define accommodation as motivation and the most considerable something to motivate them.

5.2.4 Religion of participants.

The researcher wanted to look at the participation view of motivation in terms of religion. Data shows a significant relationship between the faith of the person and what the individual defined as motivation. In terms of religion, 55.8% of Christians saw money was the primary source of motivation; 41% of Muslims said encouragement and moral support, and others (35.1%) said travel inside and outside was what they considered amotivation. These findings support the qualitative data, whereby Muslims believe in Zakat, the giving of alms to the poor and needy (Hitchcock, 2005). Zakat is one of the five pillars of Islam, therefore extending a helping hand in the form of encouragement and support was common among the Muslim participants. One Muslim female respondent from the rural area said; Money is an essential component of motivation, but from the religious point of view, which I have been taught in the Arabic school to believe, encouraging others and providing support is the greatest motivation, which is enough than money. (Rural Nurse, R17).

In doing a personal appraisal for motivation, there was a significant relationship between the religion of participants and what they perceived as their greatest motivation. Most Christians said accommodation (42.1%) was the highest motivator. While Muslims mainly preferred

money as the most significant thing to motivate them (30.6%). Traditionalists are those who do not believe in Muslims or Christian religion also favoured money (65.5%) as the greatest motivator. However, results from the focus group discussion were different from those of the survey; it was observed that during the focus group discussion, most of the participants (Christians, Muslims, and Traditionalists) said the most significant thing to motivate them was money. One of the Christian tutors aged 33 years said; As a Christian, your blessings are the riches and wealth you have, when you are blessed, you are bestowed with riches both in heaven and earth and your followers need to see the blessing of God in you, any time I go on my knees, the most significant thing I request from God is money and riches and for me never to lack or be poor for my enemies to laugh at me (Urban nurse, U10).

Concurring with the Christian colleague, a Muslim health tutor aged 25 said, “Despite everything, the greatest thing that can motivate me is money, I believe we all work for money but not for praises.” However, a few of the Muslims participants indicated that encouragement and support is the greatest thing to motivate them. One of the Muslims tutors in the rural area said; Our religion is about giving and sharing, giving is love; sharing is to care and encouragement to share in one's troubles or joy. I will instead prefer great support and encouragement from colleagues, family members, and staff than money when I am in trouble, and I prefer their advice and prayers (Rural nurse, R16).

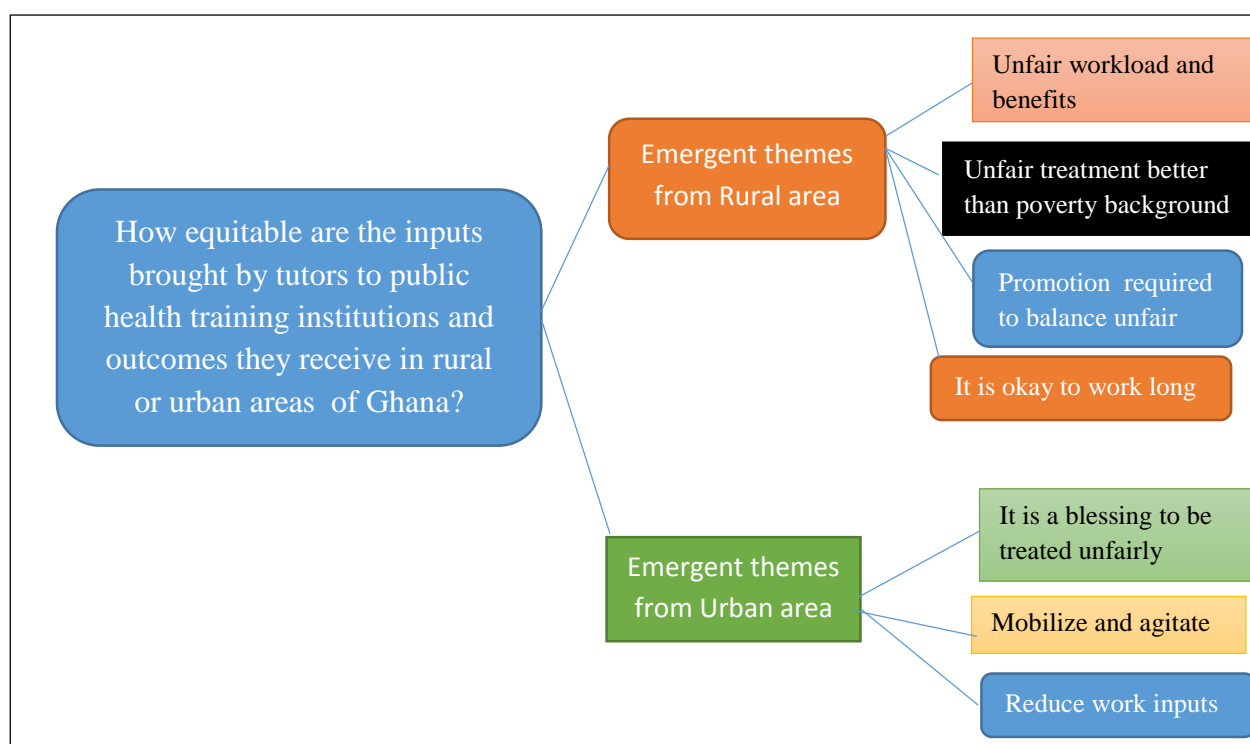
5.2.5 Marital status of participants.

In terms of marital status, there was a significant correlation between the marriage status of the participants and what they think constitutes motivation ($X^2 = 98.2$, $p = 0.000$, $df = 16$). Most participants who were never married (43.1%) said that money represents motivation, 43.8% of those married also said money, and 50% of those separated said accommodation and encouragement. Findings from the focus group discussion partly support the conclusions of the

survey, as health tutors who were never married, married, and separated all choose money as motivation. This differed a little from the survey results, which showed 50% of those separated saying accommodation and encouragement were what constituted motivation. A female tutor in the urban area, who is separated, said, “As a single parent, it’s costly to take care of the cost of rent alone, most of my salary goes to rent, in my current situation I will say what constitutes motivation is accommodation.”

This statement resonated well with other members of the focus group team who were separated. Knowing the health tutors perception of what they define as motivation and the most significant thing to motivate them, the next topic will be examining the perception of the health tutor at the workplace in terms of equity, and how the individual health tutors react to the perceived conditions of equity at the workplace.

Figure 8: Common emergent themes related to Research Question 2.



Source: Survey, 2016.

5.3 Perception of equity at the workplace

The concept of equity theory is based on the principle of balance or fairness. As per this motivation theory, an individual's motivation level is correlated to his perception of equity, fairness, and justice, practiced by the management (Carrell & Dittrich, 1978; Walster, Walster, & Berscheid, 1978). This perspective was observed in the study as the majority of tutors (73%) said they compare themselves to other colleagues to see whether their inputs correlate with the benefit they get as compared to their colleagues.

From the survey Section F, questions F1 and FGD Section D question D1, participants were asked if they compared themselves to others. It was observed that most of the tutors (73%) compared income, benefits, and qualifications to their colleagues both in other schools and within the same school. A Senior Midwife above 40 years old stated that; Yes, I sometimes

compare myself to others; for instance, in this village, there is no better accommodation, school, or food. Mostly because of the workload, you do not even have time to cook, so when you close very late, it is usually challenging to get better food to eat. But most of my colleagues or even junior officers in the cities have access to better accommodation, food, and other benefits (Rural nurse, R19). One other male tutor also confirmed the above findings by saying; “I do compare my workload, and benefit to that of my other colleagues in other schools, it’s essential to compare notes and see which benefits others are driving that you are not getting so that you are not cheated (Urban nurse, U20).

In probing further to see how the individual health tutor perceives equity at the workplace, the researcher also asked participants if they were content to work more hours than others were. Some of the participants in the study said they were personally willing to work more hours. Still, when they compared themselves to the hours of their colleagues with the same qualification, rank, and salary, they were not content; they expect more from the government. One male tutor said; I’m happy working more hours since this keeps me busy and engaged. I love to work than to stay idle. When I compare my workload with that of some of my colleagues, I feel cheated. I should be promoted and paid more because of my overtime work (Rural nurse, R16).

While most of the participants for both qualitative and quantitative surveys who compared results tended to ask for more, others compared their work and reward ratio but had no problems. Some participants who worked more hours saw it as usual and an act of destiny. A Christian male tutor believed that God destines whatever a load of work that is given, and God knows at any point in time what workload should be given to an individual, saying; My belief and trust in God give me a different perspective of life and work, whether good or bad, small or big work. I believe it’s God’s wish that is granted a particular job at a specific time. In all moments, we need to give him thanks and praise (Rural nurse, R12).

When probed further as to whether he was satisfied with working more hours than his colleagues worked, he responded, “Yes, any work or assignment i get, i believe it’s by his grace, so I am ok working more hours than my colleagues”.

Several researchers (e.g., Carrell & Dittrich, 1978; Walster, Walster, & Berscheid, 1978) believe that the theory does not hold up concerning all respondents comparing their work input and output ratio to that of others. This was observed in the survey results, as there were some (27%) who did not compare themselves to others. From the FGD question D4, some participants said they don’t compare because they are simply not interested in achieving equity or have a different perception of fairness. Some believe that once they are paid, they are supposed to work, so they do not compare themselves to others, indicating that equity is not necessarily the primary factor in their motivation. One tutor who claimed to be from a poor background believes that ‘it is wrong’ to compare oneself to others. As they are not all from the same experience in terms of wealth, he said, ‘I don’t compare myself to others, we all come from different backgrounds, others are rich, others are poor, and whatever i am given as take-home i accept it’. Another participant said; Comparing myself to another person is like comparing apples to oranges. Our DNA is different. Our purchasing power is different. The way I use my money is also different from others. Someone might work fewer hours, earn more money than me, but will only waste the money on drinks. But I might make small and invest much, so why compare? I appreciate whatever i get and don’t compare (Rural nurse, R22).

The results above show differences in the individual perception of what is fair and not fair (equity and inequity) and how they react to these situations. The next topic in this chapter seeks to explain the perceived individual reactions to equity in the workplace. It will look at three classes of different tutors and their differences (Benevolent, equity sensitive and the entitled). This is very necessary for understanding the behaviour some tutors put up in the various

training schools when they perceive inequity. This enables policymakers to develop different motivational and recruitment policies based on the individual's and school's characters.

5.3.1 Reactions to perceived equity and inequity at the workplace

The equity concept is usually used in the work context to express the positive association between one's efforts, performance, income, and other benefits one receives (Steers *et al.*, 1996). Equity sensitivity is a necessary construct to point out individual differences (Miles, Hatfield & Huseman, 1989). It is helpful to predict which type of norm an individual will follow in allocating rewards. Individuals differ in their preference and perception for getting an award. The equity sensitivity construct assumes that individuals are equally sensitive to equity, and therefore as an employer, effectively managing your staff will be essential to know how they individually react to situations of equity and inequity within the workplace. In the context of health training schools in Ghana, some are well endowed than others of 96 training institutions. This is because some institutions get more support than others either from the ministry of health or from donor partners depending on the priority area for donor partners and the ministry's priority. Therefore, knowing the individuals and how they react to inequity will assist the Ministry of Health in adequately designing a transfer policy based on the school and individual characteristics.

Huseman and his colleagues (1985, 1987) argue that there are three types of individuals who have varying degrees of sensitivity to equity; a) Benevolent, b) Equity sensitive and c) Entitled. Miles *et al.* (1994) have asserted that the relationship between the employer and the employee and the desire for outcomes differentiates one type of individual from another. At one end of the spectrum are the benevolent who emphasize the relationship with their employer. Benevolent individuals find satisfaction when they give talent and expertise to the organization.

At the opposite end are the entitled who believe their outcomes are of primary importance when dealing with their organizations. The entitled are continually looking for ways to improve their situation and maximize the rewards given by the organization. In the middle of benevolent and entitled are the equity sensitive, who place the same emphasis on having a good employment relationship and achieving the desired outcome. From the survey section F and the focus group discussion and key information interview section D, health tutors were asked if they compare themselves to others. This inquiry allowed us to determine the number of tutors who do not make comparisons with other co-workers but simply enjoyed the nature of their work.

From survey question F1, Health tutors were asked if they do compare themselves to others? It was observed that about (27%) of the tutors fall within the category of Benevolent. They do not compare themselves to others in terms of what they put in and what they receive. Seventy-three percent (73%) of the participants do differentiate themselves. From survey question F9, 68.1% who compare fall within the equity sensitives because, in their response to question F9 they said, when they are not treated fairly, they feel bad, but when they explain situations to them, they understand and are not insistent on having their right to equal resources and better conditions of services. From the survey question, D20 participants said they are aware of the financial and logistical constraints and therefore accept situations of unfair treatment when explained. Their interest is to seek to protect their relationship with their employer while 4.9% who compare based on survey question F9 said Fair treatment is my right. From the survey question, D20, the entitled said they were aware of the logistics and financial constraint but did not care about the constraint at the workplace but insist on their right to equal resources and better conditions of services, which must be provided. Below are the details of the research findings based on the characteristics of the equity sensitivity construct.

5.3.2 The Benevolent health tutor: giving more than receiving.

Ghanaians, in general, from a cultural perspective, believe in giving rather than receiving, with the belief that there is more blessing in giving than receiving. The benevolent health tutor believes in giving more of his expertise, experience, and time to improve the work than what he receives. The generous tutor thinks of how to maintain a good working relationship between himself and the employer. These are some of the characteristics of a benevolent tutor in the context of the Ghana tradition and equity.

Equity theory proposes that individuals who perceive themselves as either under-rewarded or over-rewarded will react differently to balance their reward. Individuals who feel mostly under-rewarded either reduce their work input, protest, and strike, demonstrate or use other forms of methods to show to management that their input-output ratio does not correlate, and therefore need to receive more to balance their input-output ratio. However, others believe in giving more rather than accepting, which can be described as benevolence (Carrell, 1978). This takes us to the definition of a benevolent tutor concerning this research work.

According to the oxford dictionary, benevolence is the culture of being well-meaning, kindness. Alfred Adler (Adler, 1935; Ansbacher & Ansbacher, 1956; Rychlak, 1973) categorized individuals by their reactions to others in interpersonal relationships. Salient among Adler's types is the "socially useful," the individual who "thinks more of giving than receiving" (Rychlak, p. 116- 1973) and is prepared for cooperation and contribution (Mosak, p. 194- 1959). Although psychologists are ambivalent about the actual existence of altruism (Hatfield & Sprecher, 1983), it is suggested here that Benevolent show altruistic tendencies because they give while expecting little in return. Several writers (example; Rosenhan, 1978; Rushton, 1980; Wispe, 1968) contended that empathic arousal motivates individuals to act altruistically; that is, by experiencing others needs vicariously, they are sufficiently effectively aroused to sacrifice their interests for those of others.

From the FGD and KII section D for both and from the survey section F, it was observed that the majority (73%) of the tutors do compare their input/output ratio to that of others. However, the decision to compare was dependent on factors such as individual perception, belief, family background, and location. While some tutors compare themselves to others and desire more rewards, others do not focus on what they receive but prefer to give more than they receive. From the survey data, it was revealed that location and religion play a critical role in determining the individual's perception of equity. Generally, those who come from rural areas see their current state as a 'privilege' and therefore see it as wrong to compare their lives with others. A tutor who lived his entire life in the rural area had this to say, 'It's by his grace that i find myself here, looking at the family i come from, and where am coming from, i am grateful and will not make a mistake of comparing myself to others'. Probing further as to what is meant by 'where i come from', the following information was obtained; From a typical northern home very far in the bush, we used to have only one meal a day, we did rear fowls, goats, and chicken, but all those kinds of stuff were sold to take care of the family. I am grateful to God for how far he has brought me (Rural nurse, R13).

The location impacts the individual tutor's reactions to equity, like those in the rural areas see it as performing their duty as tutors and therefore understand the need to cooperate with management (Mosak, p. 194- 1959). One female tutor who has stayed in the rural area for a long time said, 'Working 10-12 hours is normal; that is how life has always been for the past eight years. This is the only way we can sacrifice for the country'. When i probed further about sacrifice, she said; Staying in the village and giving off my best by working hard while my other colleagues in the city work a few hours, but we all earn the same amount of money per month that is a sacrifice. I give in more than i receive compared to my other colleagues in the city" (Rural nurse, R24).

In a quest to classify the individual tutors in this research, the researcher in survey question F1 asked tutors if they compare themselves to others. It was observed that 27% expressed that they do not compare their input to output ratio. Further probing in F9 wanted to confirm the question in F1, asked the tutors how do they react when they are not treated fairly, and a further 27% confirmed they do not have a problem if not treated fairly. This fairly reflects the characteristics of Benevolence who do not care about giving more than receiving. From FGD, some tutors expressed the same view from a religious point, whatever they are given is what they deserve, and therefore they are content, as shown by this tutor; I prefer to give more than to receive, the bible says there is more blessing in giving than receiving, we all know the teacher's reward is in heaven but not on earth, so I build my treasures in heaven rather than on earth. The blessings I receive for the excellent work done is worth more than money (Urban nurse, 12).

A Muslim female tutor confirmed her belief in giving more than receiving by saying, “my work for this school can never commensurate with pay, so I don’t even think of comparing; my religion tells me that there is more blessing in giving”. From the comments stated above, this group of health tutors had strong characteristics of the benevolent equity person, who does not care much about what he receives than what he gives. The circumstances and mindset of this group of tutors place them in a class of people who believe in giving more than receiving (Rychlak, p. 116- 1973). These tutors have an attitude of gratefulness, and they are often kind and ‘benevolent’, they believe in working and cooperating with management to contribute their quota irrespective of what they receive (Mosak, p. 194- 1959). Generally, benevolent group members are givers (Blau, 1964). Their contentment derives from perceptions that their outcome/input ratios are less than those compared to others are. This research finding supports the literature on the existence of (27%) benevolent equity health tutors in the workplace in Ghana.

Results from the survey question B14 and 15 indicate that most health tutors in the rural area

(northern) work an average of 2.7 hours of overtime while those in the urban (greater Accra) work overtime of 0.53 minutes. However, when tutors were asked in survey question B16 if they were ok to work more extra hours than expected, many rural tutors (87%) said they were agreeable to working more hours than their urban colleagues. The results from the survey also confirmed those of the focus group discussions in the north. One of the tutors in allied health said; I have no problem working all day long in this village, others might think i am overworking and therefore, a fool but i do not care what others say; my part is to give my best (Rural Allied, RA2).

The benevolent characteristics of staff in the rural area were further demonstrated by the fact that they were willing to continue working there, despite the more significant workload and less reward. This situation was confirmed when a logistic regression with a model fit of 80% was carried out. The analysis showed that the chance of a tutor who wants to work more hours leaving the rural area is 2.3 times less likely than a colleague who wants to work fewer hours. Most of this group of tutors are often found in rural areas. Although one would think that working more hours than a colleague in the urban area could be a demotivating factor to those in the rural area, data from the survey shows that those who work more hours (who are mainly in rural areas) are motivated to work regardless of the circumstance. They prefer to give more compared to what they receive. This further supports the literature on benevolence health tutors in the health training institutions who offer more but expect less.

One other important characteristic of benevolent equity persons is the experience they derive from work above reward when they give more than they get. From the research findings, it was observed that some health tutors who work more hours perceive that job exposure and experience is much more critical than the reward you receive. This was amply demonstrated in the focus group discussions. A newly posted young tutor said; I have gained more experience than my other colleague in the city, and he told me he is not given much to do and not involved

in work, I am fully involved in work here, and I am happy that has given me more experience in life. Money cannot buy experience, but the experience can earn you money (Rural nurse, R24).

The comments of the newly posted young tutor fit the equity theory because he is comparing himself to his other colleagues in the city. If what he is putting in at the workplace commensurate with what he is getting back and quantifies the experience gained from being involved in work in the rural area, he is learning more than his other colleagues in the city in terms of experience. He highly values the expertise than social amenities and other things enjoyed by his colleagues in the city. One of the tutors, who is a Muslim and from the north said; We were taught to sacrifice by working hard, and that has always been our principle. Hard work pays and doesn't kill, so from where I come from, we work hard but do not think of what is given (Rural nurse, R16).

It is worth noting that such traits are not only found in the rural area but also in the urban area, where one tutor said, "I have to work hard to promote the image of the school but not my self-interest, whatever i am given, i accept it, and it's ok for me, the experience is what i want for the future". As part of the research questions, tutors were asked, 'what will encourage you to stay in the rural area? This question was asked to discover significant factors that influence the tutor's choice of location.

Data from the survey question E2 and E3 indicate that 67% of the tutors from the rural area expressed their desire to teach not because of money, allowance, or financial benefit but for the inner satisfaction they derive from teaching. They give out of will and interest while expecting little in return (Hatfield & Sprecher, 1983). Some of the intrinsic reasons given in the focus group discussion to support the quantitative results include the joy of imparting knowledge to others, the intuitive feeling of the job, and respect from students and society. During the Focus group interview, one of the tutors said;

I do enjoy the respect from my students any time they see me in a car, and they get up for me to sit when I enter the classroom. They get up and stand for me to enter the class. Even some of the students buy me gifts just to show how much they value and appreciate you (Rural nurse, R21).

Tutors admitted that most of the students respected them and that that was one of the things that motivated them and caused them, in turn, to stay with these students. Apart from the respect from students, which formed the pride of the tutor, some also reported the joy of seeing their former students in uniform at the hospital, delivering services to the poor and vulnerable. This created a feeling of having made an impact on society and contribution to their nation. One tutor said;

There was an accident, and I went to the hospital to visit a relative, and when I turned around, I saw one of my former students who said, hello sir, how can I help you? I am the nurse on duty. I was filled with joy to see my student at my service. All the other visitors and patients were amazed, they showed me so much respect, and some even started calling me a doctor. I am proud to be a health tutor. I will retire from a health tutor (Urban nurse, U18).

The feeling of seeing your students come to your aid, comfort the sick, and help the dying has remained a critical motivational factor for retention. As the 42-year-old tutor said, she wishes to stay in tutorship for the rest of her life; such is the pride of the health job and the inner satisfaction she gets from teaching. Upon completion of the examination of the benevolent health tutor, it is now appropriate to revise equity from the Equity sensitivities.

5.3.3 Equity Sensitive - Compared to others, do I receive my due?

The Equity Sensitivity Construct describes a spectrum of varying sensitivities to equity and inequity (Huseman et al., 1987). The idea of equity sensitivity determines the extent to which an individual will tolerate inequity. Individuals are happier and experience less tension when

they are equitably rewarded than experiencing under-reward or over-reward (Austin & Walster, 1974).

Equity Sensitive individuals represent the traditional equity theory model of tutors evaluating their relationships with others by assessing the ratio of their outcomes and inputs to the ratio against the outcome/input ratio of comparison to others. If the outcome/input ratios of the individual and comparison to others are perceived to be unequal, then inequity exists. The higher the injustice the individual sees (either over reward or under reward), the more distress the individual feels. The higher the difficulty an individual feels, the harder they will work to restore equity and, thus, reduce the suffering (Carrell & Dittrich, 1978; Walster, Walster, & Berscheid, 1978).

From the FGD and KII section D for both and from the survey section F, it was observed that tutors compare their feeling of inequity on the work side mostly because the effort they put in is more significant than the reward they receive. Tutors, however, had different ways of expressing situations of perceived inequity at the workplace. Tutors said in the focus group that some ways to react to perceived injustice when they are under-rewarded at the workplace included refusal to teach or a sit-down strike. Still, a more significant majority of the tutors mentioned the refusal to hand over students' results. One of the tutors in the urban area said; It's easy to express our frustration and grievance if, after putting in so much time and effort to mark scripts, and the principal does not pay us our marking allowance. We do not give her the marked scripts, and the term is marking allowance, so no compensation, no marks (Urban nurse, U14)

Other tutors believed that not handing over marked scripts amounted to insubordination and breach of the contractual agreement as a tutor. It was further explained that marking of scripts and handing them over on time is part of a health tutor's job description, and therefore not doing so could be a breach of contract. One of the health tutors in the rural area said;

I will hand over my marked scripts, report to the school, as usual, go to the staff common room to read and not attend a lecture or teach; when the students are not taught, they will petition administration, and I will then also tell them why am not teaching because I am not receiving what I merit (Rural nurse, R9).

From survey question F9, 68.1% of the health tutors who compare themselves have the characteristics of equity sensitive's because, in their response to question F9 they said, they were not treated fairly, but when they explain situations to them, they understand and are not insistent on having their right to equal resources and better conditions of services. From the survey question, D20 participants said they are aware of the financial and logistical constraints and therefore accept situations of unfair treatment when explained. Their interest is to seek to protect their relationship with their employer. From the survey questions B19, it was also further observed that the minimum allowance for marking of scripts given to tutors for one year was between 100-499Gh while the highest given was above Gh2000.

Table 16 :Allowance for marking of scripts received by health tutors in Ghana Cedi

August 2014 – August 2015		Frequency	Percent
	100 – 499	185	56.2
	500 – 999	48	14.6
	1000 – 1499	20	6.1
	1500 – 1999	8	2.4
	Above 2000	68	20.7
Total		329	100.0

Source: Survey, 2016.

Although it is clear from survey questions B19 that tutors did receive marking allowance, survey questions D3 confirm the perception that most health tutors (73.9%) believe that their input was still higher than the benefits they received in the form of an allowance. Therefore, they were disappointed with their financial rewards, which lead to a perception of inequity on the work side from their subjective view. The reference point for equity sensitive construct is often placed on monetary value (Miles, Hatfield & Huseman, 1989). Equity sensitives are most content when their outcome/input ratios equal those of the comparison other.

Table 17: Perception of tutors on grading allowances

	Frequency	Percent
Very disappointing	224	73.9
A bit disappointing	41	12.5
A bit satisfactory	29	8.8
Satisfactory	5	1.5
Very satisfactory	11	3.3
Total	310	94.2
Total	329	100.0

Source: Survey, 2016.

The survey results confirm the findings from the focus group discussion; some tutors perceived that their qualification and workload compared to what they receive does not merit their reward, and therefore they need to establish a balance between what they give out to the institution and what they receive. In some instances, when tutors perceive that management or leadership is receiving more than their fair share to the neglect of their interest, this could result in actions such as demonstration to press home their demand for an equitable and fair share of the school's resources. An example of this occurred during a re-visit of the study area to validate the data collected when some of the tutors of the Kintampo College of Health and wellbeing were in a perceived state of equity sensitivity decided not to participate in an ongoing admission interview in their school due to perceived inequity. They wore red bands to signify their displeasure and anger, and the picture depicted that the leaders of the strike were mostly males (see figure 8 below).

One of the characteristics of a sensitive equity individual is that their reference point is often in monetary value, hours of work, and qualification. In the situation which led to the demonstration, the tutors believed their hours of work, qualification, and experience were the same. Still, they were paid less and therefore demonstrated to pressure for equity. One of them said; They don't know that we are brilliant; we can easily find out how much each one receives per interview session of 8 hours a day and compare it to other colleagues in the different departments. We are very sensitive to that. I would have found out how much my other colleagues are receiving to see whether there was fairness (Rural Allied, RA5).

It must be emphasized that the equity sensitive will often need explanation and justification as to why his colleague is receiving more than him, which could often avert situations of demonstration, strike, et cetera. Therefore, the tutor above, who would find out about his other colleagues and compare what they earned because he was 'sensitive to situations' explaining the variations in amount or earnings at the workplace and why such occurrence could help calm down tempers.

Figure 9: Kintampo tutors react to perceived inequity



Source: Survey, 2016.

It is, therefore, imperative to note that the equity sensitive is in between the benevolent and the entitled, which will be discussed next.

5.3.4 Entitled tutors - My rights to rewards.

The label Entitled is taken from Coles description (1977a, 1977b), which used the term to describe the affluent child who 'has much, but wants and expects more, all assumed to be his or hers by right-at once a psychological and material inheritance the world will provide' (Coles, p. 85- 1977). Greenberg and Westcott (1983) extended Coles concept of entitlement to the general population; they described Entitled as having high thresholds for feeling indebted: "Whatever aid outcomes they receive is their due, and they therefore feel little or no obligation to reciprocate. They exist in a world where all but one are debtors" (p. 105). Adlerian psychology also provides the conceptual basis for entitlement. In sharp contrast to Adler's socially useful (Benevolent) individual, the 'getting type' exploits and manipulates life and

others by actively or passively putting others into his service. He tends to view life as unfair for denying him that to which he is entitled.

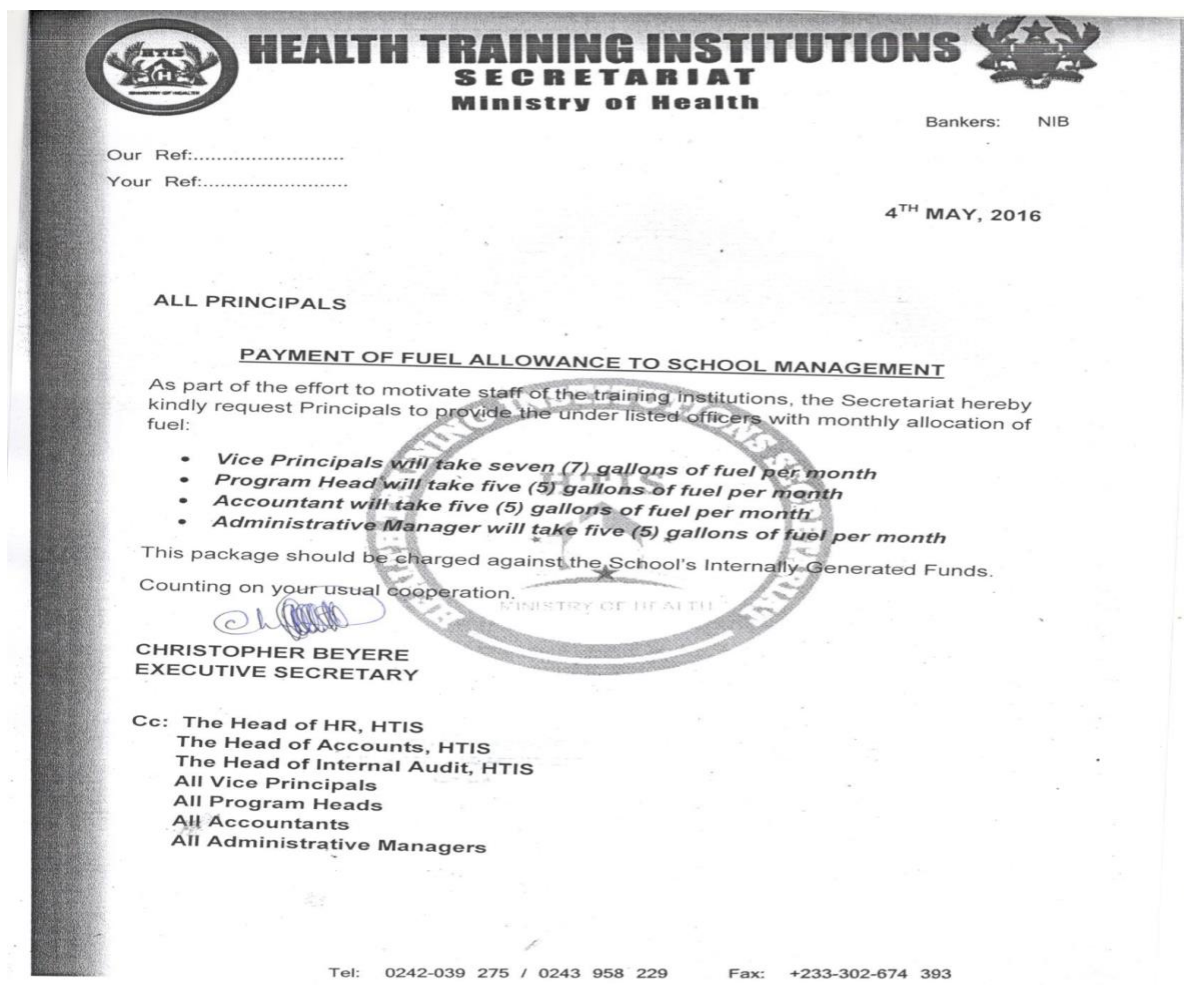
The key informant interviews with Principals showed that most of them (4 out of 5 Principals) complained about a lack of funds from the central government, which means that health-training institutions are not able to pay for car maintenance allowance, rent allowance, or fuel, among other things. As they do not receive these allowances, some health tutors who feel they are entitled are usually demotivated, and sometimes do not aspire to make sacrifices. Probing further in section D, question 3 of the key informant guide to clarify differences between health tutors, I asked Principals how various tutors react in terms of inequity. One principal responded by saying; You can see those who feel and claim they are entitled to something; usually, those people are arrogant, proud, disrespectful, and cultural and professional unfit to be health tutors. They talk anyhow to the Principal when you do not pay them. They feel they are entitled, so you must. No amount of explanation will let such people understand you (Principal Urban, PU1).

Confirming the above statement, another Principal also added that; The entitled people are usually rebel leaders. When they demand what is in their conditions of service (showing me an example below, fig 4) and you tell them to wait for the right time, they don't understand. They talk rudely and go to mobilize the others to fight you (Principal rural, PR1).

Confirming whether the above perception existed from the tutors, one of the senior health tutors, who is perceived to fall within the equity frame of entitled health tutors, said; As part of the conditions of service for me as a vice principal, I am supposed to get 10 gallons of fuel per month from internally generated funds but am not given anything; however, the Principal enjoys all allowances, including that of fuel, if this should continue I have no option than to resign from the vice-principalship since there is no benefit (Urban nurse, U12).

The Vice-principal, strengthening her point, showed evidence (see Fig 10 below) that she, as the vice, was entitled to allowances, but was being denied.

Figure 10: Payment of allowance to school management



Source: Ministry of Health, 2016.

One of the tutors also submitted that as a chief health tutor within the category 1 and 2 of the public service schemes, she was entitled to a particular travel allowance, night allowances and accommodation allowance, however they have been denied. He said; I have a letter from the health training institutions secretariat and the public service joint standing committee on my desk, which shows what I am supposed to be given every month; whether principals like it or not, we will have to be provided what is stated in conditions of service else the school will have to be closed down. No amount of explanation or pleading will stop some of us from the decision we have already planned (Urban nurse, U26).

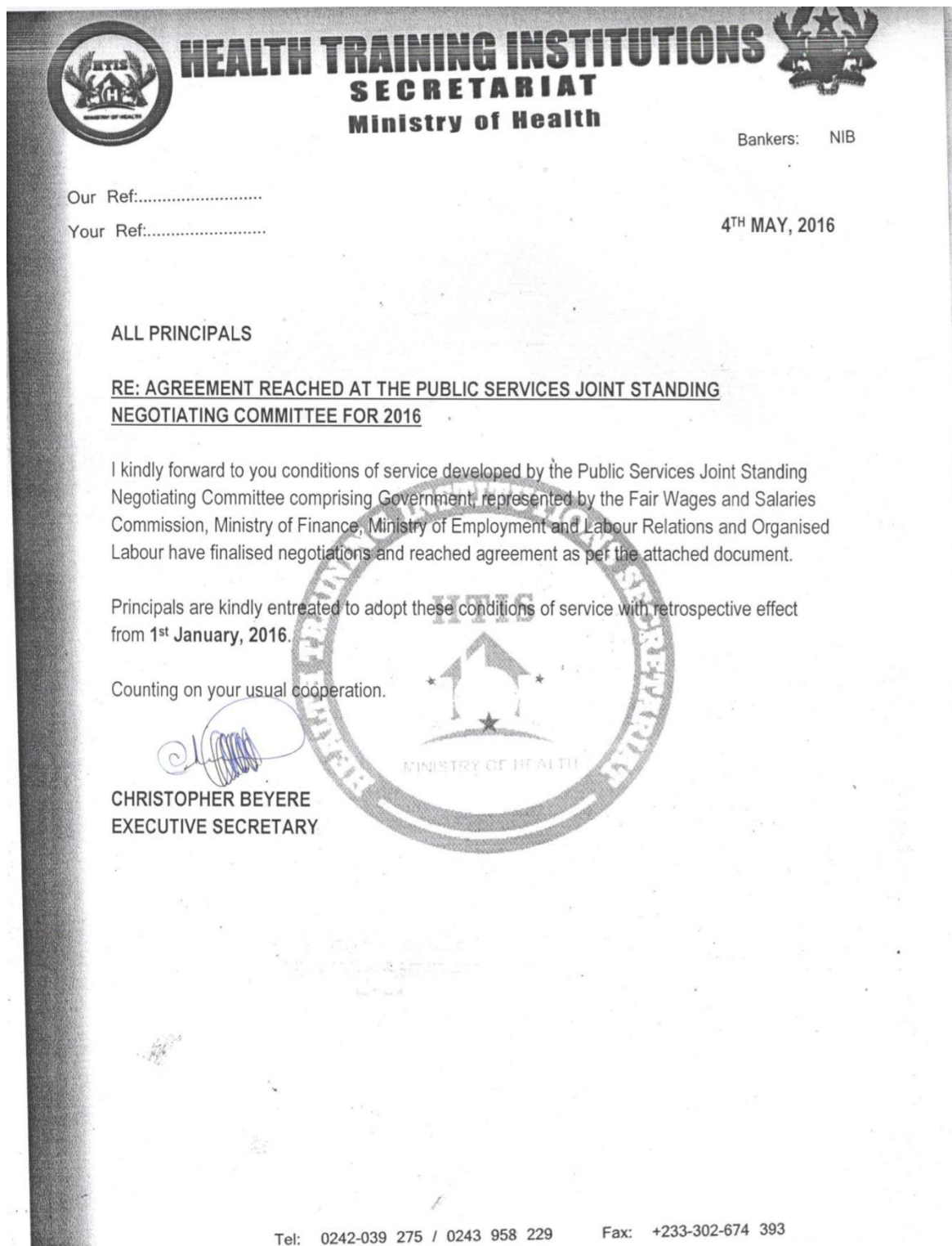
The story of the Principals and Tutors about inequity confirms the apparent characteristics of the entitled who, according to Greenberg and Westcott (1983), have high thresholds for feeling indebted: ‘Whatever aid (outcomes) they receive is their due, and therefore they feel little or no obligation to reciprocate. They exist in a world where all but one are debtors’ (p. 105). When the Principals tell the tutors there is no money, they see the Principals as debtors and recognize no obligation to be patient. For the entitled tutor, whether there is money or not, it must be produced for them; no explanation can stop them from carrying out what they have already planned. Comparing the three groups (Benevolent, Equity sensitive and Entitled), the benevolent would not bother at all, the equity sensitive would compare, but when you explain the current financial situation in the school, they would understand, while the entitled are not sympathetic, they do not care about the case, and all they want is to be given what they are entitled. Whether you steal, borrow, or sell the school, they do not care but want their entitlement. This explains the fact that some of the tutors, no matter how best you try to explain to them the current painful condition, remain insatiable and feel they are entitled (Mosak, p. 78- 1971). One of the principals said; With the implementation of allowances for tutors starting from January 2016, the government will have to bring money to pay for those allowances because schools cannot afford, and this will lead to demonstration and sit down strikes as tutors will not understand why they are not being given what they are entitled. Still, the answer is there is simply no money to pay for that. No matter how much time you spend explaining to them, the financial constraint tutors will still insist on getting what is approved on paper (Principal Rural, PR).

Some health tutors (4.9%) who compare themselves based on survey question F9 said Fair treatment is my right, and from survey question D20, the entitled are aware of the logistics and financial constraints but do not care about the constraint at the workplace but insist on their right to equal resources and better conditions of services, which must be provided. This was

further confirmed by the focus group discussion where tutors felt they were entitled to a uniform allowance, protective clothing allowance, and others, as stated in the approval from the joint public service team below (Fig 10), but who have not received them. The feeling that their entitlement was not being met made them feel unmotivated. One of the health tutors showed me a letter from the health training institutions' secretariat and said; Look at this, we are entitled to many things, but we are not given, some schools provide for their staff, but our school does not, all that principals will tell us is that there is no money, but it's our right so that we will fight for it (Rural nurse, R15).

The health tutor felt a sense of betrayal and breach of contract, especially when she compared herself to other colleagues in other schools; she vowed to fight for her entitlement. It must be emphasized that some schools are better supported with adequate resources than others, so knowing the characteristics of the entitled could enable policymakers to place them appropriately in the various schools. Assigning them in a new health training institution that is less endowed could demotivate the few (4.9%) of the entitled tutors who would not teach but continuously present enormous challenges to the Principals. The entitled tutors could also influence others to protest what they perceive as inequity. It is, therefore, necessary to know the individual characteristics to manage them effectively.

Figure 11: Joint public service agreement on conditions of service



Source: Ministry of Health, 2016.

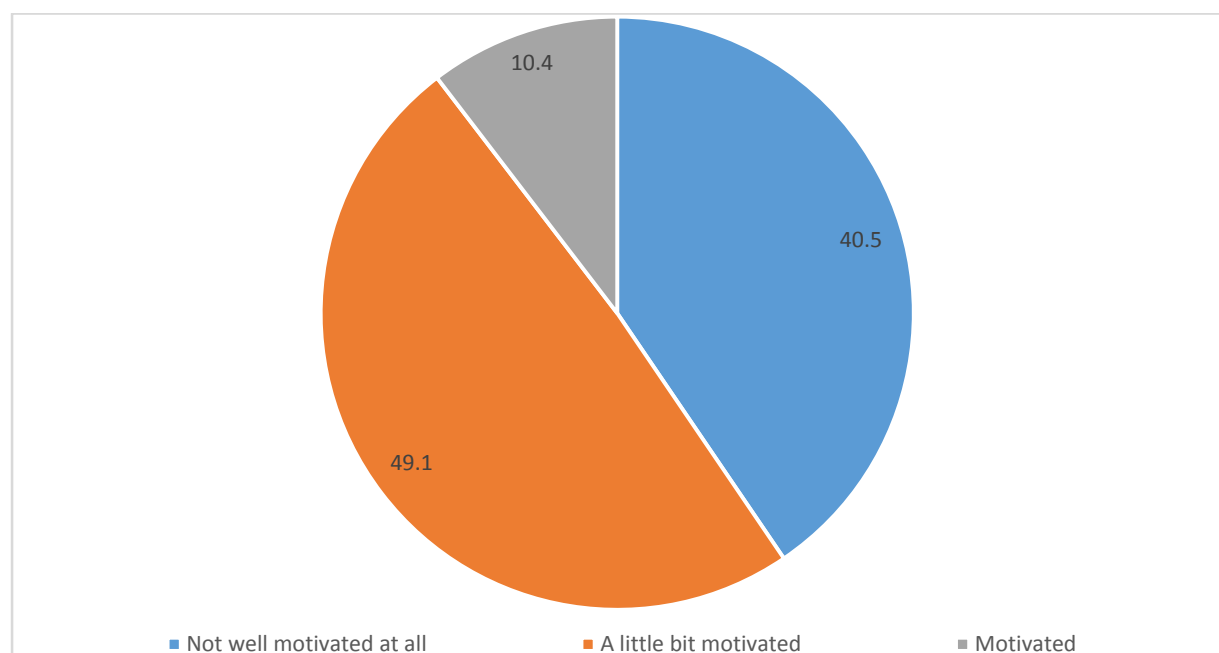
The research findings explain the difference in health tutors in terms of their perception of equity at the workplace and how they react to situations of equity.

In the next section, we will be focusing on the health tutors motivation at the workplace and their overall level of motivation.

5.4 Level of motivation by the Ghanaian health tutor

Having looked at motivation from the perspective of the appraisal of motivation, perceptions of equity, and their reaction to perceived conditions of equity and inequity at the workplace, this next section of chapter 5 will look at the level of motivation of the health tutors. It seeks to answer the question, how motivated are the health tutors in Ghana? Is there a difference in motivation in terms of geographical location, sex, marital status, or religion? Knowing their level of motivation based on their sociodemographic characteristics will enable the ministry of health to develop various motivation policies that will help improve current levels of motivation and allow them to stay in tutorship. The individual health tutors were asked in survey question E10 to undertake a self-evaluation of their motivation level at the worksite. The results are shown in figure 12 below;

Figure 12 : The overall level of motivation



Source: Survey, 2016.

Surprisingly, from the survey data, it was observed that there was no significant relationship ($X^2 = 9.8$ $p=0.07$, $df = 2$) between where a person lives and an overall level of motivation. When tutors were asked to indicate whether they felt motivated, a little motivated, or not motivated, the majority of tutors in urban areas felt a little motivated (57.3%) compared to 40.3% of tutors located in rural areas. Many tutors in the rural area were not well-motivated (49.6%) than 32.0% from urban areas. Overall, motivation levels were high for approximately 10% of tutors in both rural and urban areas (urban = 10.7%, rural = 10.1%).

This was further confirmed in the qualitative study, where most of the tutors were not motivated. Tutors complained of low salaries, lack of allowances, and lack of training equipment for tutors as reasons for the low level of motivation. One of the senior tutors said; For my entire 16 years of work at the training school, i have never felt motivated, i am not given accommodation, scholarship to study abroad, delayed promotions and maltreatment, and event logistics to work with at the classroom is a big problem so how can our overall level of motivation be right? It's wrong, go and tell the minister, we are not motivated at all (Rural nurse, R19).

The researcher wanted to know if there were any differences in the overall level of motivation in gender. It was observed that both male and female tutors mostly see themselves as a little bit motivated (males = 50.6%, females = 47%). However, only 8.7% of males and 12.1% of the females said they were motivated, compared to 40.7% and 40.2% of males and females, respectively, who said they were not well motivated. The same results were observed for the qualitative data, with both sexes saying they were not motivated.

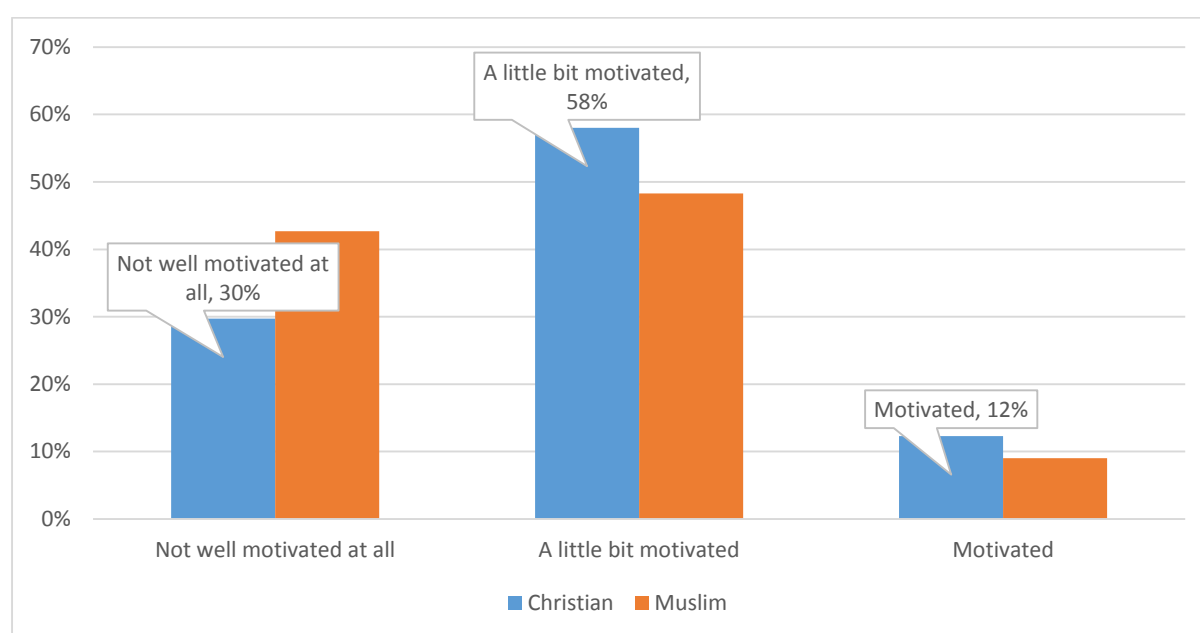
Analysis of the data looking at the level of motivation by age group indicates a significant association between the different age groups and their overall level of motivation ($X^2 = 19.0$, $p = 0.04$, $df = 6$). Of the three levels of motivation surveyed, the majority of participants within the age group 20-29 said they were a little bit motivated (43.9%), most of those within the age

group 30-39 said they were not well motivated at all (46.1%), and the majority of the 40-49 and 50-59-year-olds said they were a little bit motivated, (65.7%) and (57.1%) respectively. Feelings of being highly motivated by all age groups were low, with only 11.2% of respondents saying they were excited. A similar pattern was observed in the qualitative study as most of the tutors within the age group 20-29 said they were motivated to get a job right from school that pays above GH1000. According to the tutors within the age group 20-29, most of their friends are still at home unemployed, and to them, it was a privilege to get a permanent job. For example, a 21-year-old newly recruited tutor posted to the rural area said; Out of 60 students, I am the only one to have gotten a job as a tutor immediately after university. I am motivated now with what I am given, at least for a start. I see hope in the future. I am better off than most of my colleagues who are home unemployed, so to me, it's ok (Rural nurse, R28).

It was also observed that similarly, those within the age group of 30-39 years were not motivated. They felt they had worked for some time, but no promotion or recognition, and therefore they were not well motivated. One of them said; Compared to my other colleagues, I started work with some six years back. They have gotten promotions. Some have even had the opportunity to travel outside the country for a short course, but I am here without any promotion for six years and no motivation; tell the ministry of health to motivate us or well will all leave (Rural nurse, R17).

Interestingly, results for the focus group were similar to that of the survey for the age group 40-49 and 50-59 years, as most of them said they were not well motivated. Looking at individual tutors and their religion (Figure 13), 58% of the Christians said they were a little bit motivated, and 30% said they were not motivated at all. Only 12.3% said they were motivated. With the Muslims, 56.9% said they were a little bit motivated, and 36.9% said they were not motivated at all, with only 6.2% saying they were motivated.

Figure 13: Distribution of levels of motivation of health tutors by Religion



Source: Ministry of Health, 2016.

The association between the religion of the participants and their overall level of motivation was found to be statistically significant ($X^2 = 25.2$, $p = 0.001$, $df = 8$). A similar pattern was observed in the quantitative study, as most of the participants said they were a little bit motivated. This was obvious across all the regions as they all expected the Ministry of Health to improve current conditions of service. One of the Christian health tutors said; We pay utilities, take care of families, and also pay for transport. The cost of living is becoming very hard, so the government can improve our motivation by increasing salaries by 15%. This will make us happy, but for now, we are not saying we are not motivated at all, but just a little bit (Rural nurse, R28).

There was no significant association between the marital status of the respondents and their overall level of motivation. From the analysis, 48% of those never married said they were not motivated at all, 40% a bit motivated, and only 12% were motivated. Of those married, 51.2% were a bit motivated, 39.1% were not motivated, and only 9.8% were motivated. Fifty percent

of those who were separated said they were not motivated at all, and another 50% said they were a little bit motivated.

The study results show that the respondents were less motivated at their workplaces than their colleagues teaching at the university with the same qualification. Money, accommodation, encouragement, and support were what motivated them the most. They were happy with what they were currently doing but were still some factors that needed to be addressed to improve their level of motivation. For example, according to the results, the tutors expected an increase in salary, provision of allowances, opportunities to attend workshops, and encouragement and support at their workplaces. This could help motivate them to teach and to stay in tutorship.

The next chapter will look at the topic of retention, a critical part of employee motivation. In a resource-constrained country like Ghana, where tutors feel less motivated, what are the views of the health tutor in terms of retention? Do the health tutors have preferred locations? If so, why, and what can be done to get the right staff mix. These questions and others will be discussed in the next chapter (retention).

CHAPTER 6

STAFF RETENTION

6.1 Introduction

This chapter focuses on health tutor retention. Retention is the ability of an organization to engage valuable staff for an extended period. It is a voluntary move by an organization to create an environment, which engages employees in the long term (Michael, 2008). It is essential to state that there is a link between motivation and retention. Afenyo (2012), in his study of motivation effects on retention in a private sector in Ghana, found that motivation has a significant positive result on retention. Sajjad et al. (2013) found that motivation has a substantial effect on workers quitting jobs in Pakistan; this indicates that a rise in motivation in-turn enhances employee retention. This chapter will have three sections. The first section will seek to find out how postings to the various training institutions are carried out, whether it is by choice of the individual or of the Ministry of Health based on need and vacancy. The second section will examine retention within the Ministry of Health; the researcher will explore why health tutors choose rural or urban areas within the same ministries. The final section will highlight the story of two past health tutors and a principal on the reasons why health tutors move or seek jobs outside the Ministry of Health, and where they prefer to move to when they leave the Ministry of Health.

6.2 Health tutors posting

There is extensive literature on factors affecting choices of location, which have been well summarized in some reviews (Dieleman, 2006; Lehmann *et al.*, 2008). This section looked at health tutors' postings to rural and urban areas and how that was done. This enables us to know if all health tutors were given the same opportunity to choose their location of work or were

treated differently by allowing them to choose their place of work while others were not given that opportunity. This is in line with my theory of equity at the work place. Starting with the frequencies and descriptive statistics, the researcher first looked at the respondents views regarding posting. The researcher wanted to know if the posting was based on an individual tutor's request or from the Ministries of Health directly.

From survey question B23. It was observed that the majority (63.1%) of the health tutors were posted by the Ministry and not at their request. However, over one third (36.9%) had a choice of requesting for their posting.

Table 18 : Respondents request for postings

Category	Frequency	Percentage
Own request	120	36.9
MoH postings	205	63.1
Total	325	100

Source: Survey, 2016.

The researcher wanted to conduct further analysis by looking at the individual locations, urban and rural, to ascertain how many of the health tutors requested posting specifically to the rural area or the urban area, or whether they were deliberately posted to these locations.

Starting with the rural area, it was observed from survey question B24 that only one-third (33.9%) of health tutors from the rural area requested a posting to their current location (rural). However, two-thirds (66.1%) of the health tutors were posted to the rural area by the Ministries of Health.

Table 19: Respondents request for posting to the rural area (*those in a rural area only)
N=153

Category	Frequency	Percentage
Own request	52	33.9
MoH postings	101	66.1
Total	153	100

Source: Survey, 2016.

Only a few requested posting to the rural area (33.96%); from B25, it was observed that the majority of the health tutors in the urban area (70.8%) personally requested posting to the urban area while a few (29.2%) were posted to the urban area by the ministry of health.

Table 20: Respondents' requests for posting to the urban area (*those in the urban area only)
N=171

Category	Frequency	Percentage
Own request	121	70.8
MoH postings	50	29.2
Total	171	100

Source: Survey, 2016.

6.3 Retention within the Ministry of Health

This section specifically explored key reasons for staff moving from rural to urban and from urban to rural with the ministry of health. It will look at reasons for health tutors wanting to work in the urban areas within the same ministries, which will then be followed by looking at the reasons for health tutors wanting to work in the rural areas within the same ministry of health.

6.3.1 Reasons for wanting to work in the urban area.

A regression analysis was used to identify the factors predicting preference for urban over rural locations for work. The model was a good fit with the final model, having a p-value of 0.00 compared to the null model. The dependent variable used for the analysis was “where would you like to move to”? With the option being to move to an urban area. It was found that health tutors in the rural area leaving the Ministry of Health training institutions in Ghana are 1.40 more likely to move to the urban area after having worked for at least one year or more in the rural area. Some of the reasons from the survey section E question E3 shows some of the reasons why health tutors want to work in the urban area based on a multiple regression analysis are shown in table 21.

Table 21: Employee choice, urban (as Dependent Variable) on the Motivational Variables (as Independent Variable)

Variables	Unstandardized Coefficients			Standardized Coefficients	
	B	Std. error	Beta	t	Sig.
Constant	1.241	.093		13.296	.000**
Social amenities	.079	.012	.255	6.706	.000**
working environment	.071	.011	.243	6.162	.000**
Promotion	.063	.012	.202	5.026	.000**
Training and development	.041	.013	.123	3.145	.000**
Schools for children	.053	.013	.156	4.129	.000**
Interesting work	-.005	.013	-.414	-.01	.679
Money	.049	.013	.142	3.760	.000**
Recognition	.046	.012	.131	3.712	.000**

Source: SPSS result from survey data, (2016). R Square .83 ** P < 0.01

The results from the survey show that the most influential factor that significantly affects the employee choice of location is social amenities, with a beta value ($\beta = 0.255$), at a 99% confidence level ($p < 0.01$). Therefore, it can be said that social amenities have a positive and significant effect on employee choice of location to the urban area. This correlates with that of the qualitative study as most of the people in the rural area ranked social amenities as positive to them. One male tutor in the rural area, answering question 18 in FGD, said; ‘I want to work in the urban area because of the lack of social amenities here. I have worked for close to three years without any better entertainment’ (Rural nurse, R11).

The results also show that the working environment has a positive and significant effect on employee choice of location in the urban area, with a beta value ($\beta = 0.243$), at a 99% confidence level ($p < 0.01$). Similar results were observed in the focus group discussion, as tutors expected schools to look neat, beautiful, and structured. One tutor said; ‘Most of the old schools are well built and properly planned although old. The structures are already there, and tutors don’t struggle for office accommodation and other things unlike new schools where development is ongoing (Urban nurse, U11).

From the table, promotion has a positive and significant effect on employee location with a beta value ($\beta = 0.202$), at 99% confidence level ($p < 0.01$). In the focus group discussion with health tutors in the urban area, some of them alluded that they believed in receiving prompt notice on promotions and other important messages more than their counterparts in the rural areas receive. According to the tutors, letters do not sometimes even get to their counterparts in the rural areas on time, but they receive instant and prompt messages on staff promotions. One of them revealed, ‘In Accra, I am very close to the headquarters, so i periodically visit the head office to find out if there are opportunities, especially during promotions so to me the urban location is good’ (Urban Allied health, UA7).

The table further shows that schools for children have a positive and significant effect on employee movement to the urban area with a beta value ($\beta = 0.156$), at a 99% confidence level ($p < 0.01$). This was also observed during the focus group discussion as most participants said the availability of good schools in the urban area was one reason for their choice to stay there. In supporting the idea, a middle-age health tutor said; ‘The cost of living in the urban area is high, but there are better schools here for my children. Their future is vital for me, I couldn’t become a medical doctor, but I want my son to be’ (Urban nurse, U17).

From the results, money has a p-value which is significant ($p < 0.01$), at 99% confidence level and a positive beta value of ($\beta = 0.142$). This was, however, different in the focus group discussion, where many expressed that it is tough to save money in the urban areas despite performing extra work in the private sector as the money gained goes back into utilities, food, and payment of social amenities. The cost of accommodation, food, and utilities is quite high in the cities. Attesting to this, one of the tutors said, ‘In the urban area, you get money, but all the money goes back to expenditure so you cannot save at all’ (Urban nurse, U12). As shown in the above, training and development have a positive and significant effect on employee choice of location in the urban area with a beta value ($\beta = .123$), at a 99% confidence level ($p < 0.01$). Tutors who opted to be posted to the urban area from the rural area during the qualitative study mostly said there were more opportunities for further training and development in the urban areas, where there are institutions of higher education.

One observation different from the others previously discussed is that of ‘interesting work’. The p-value is not significant ($p > 0.01$), and the beta value of interesting work was negative ($\beta = -0.414$). Therefore, an interesting job does not influence the health tutors’ choice to move to the urban area. Some tutors also expressed the same. One health tutor from the rural area said, “My interest to move to the urban area is because of the social amenities and

opportunities for further studies but not because working in the urban area is interesting” (Rural Allied Health, RA13). The results also show that the working environment has a positive and significant effect on employee choice of location to the urban area with a beta value (beta = 0.131), at a 99% confidence level ($p < 0.01$). A similar observation was made during the focus group discussion.

Concluding this section, the table above indicates that all the independent variables accounted for 83% of the variance in employee choice of location to the urban area ($R^2 = 0.83$). Thus, 83% of the variation in employee interest in the urban area can be explained by the motivational variables, and the other 17% cannot be explained using the table. The results also show that social amenities are the most influential factor that significantly affects employee choice of location to the urban area.

6.3.2 Reasons for wanting to work in a rural area.

Shifting our attention from urban to rural, rural areas represent large, isolated areas of a country, often with low population densities and relatively poor infrastructure (WHO, 2010). Remote rural communities always suffer from higher rates of poverty than their urban counterparts (Munslow and O'Dempsey, 2010). Trained, skilled, and motivated health workers are essential to delivering high-quality health care services. As noted in the previous section in this chapter, most of these skilled health workers prefer to work in an urban area than a rural area. However, some groups of health workers would want to work in rural areas. The multiple regression analysis from the survey section E question E2 shows why health workers wish to work in rural areas.

Table 22: Employee Location, Rural (as Dependent Variable) on the Motivational Variables (as Independent Variable)

Variables	Unstandardized Coefficients			Standardized Coefficients	
	B	Std. error	Beta	t	Sig.
Constant	1.241	.093		13.296	.000**
low cost of living	.068	.011	.248	6.606	.000**
Recognition	.055	.011	.233	6.152	.000**
Accommodation	.031	.012	.113	3.135	.000**
Inner desire to serve in a rural area	.043	.012	.136	4.119	.000**
Patriotic	-.005	.013	-.314	-.01	.569
No traffic	.049	.013	.142	3.760	.000**

Source: SPSS result from survey data, (2016). *R Square .83* ** $P < 0.01$

From the table, the most influential factor that significantly affects the employee interest to serve in the rural area is the low cost of living with a beta value (beta = 0.248), at 99% confidence level ($p < 0.01$). Therefore, it can be said that the low cost of living has a positive and significant effect on the employee interest to move to the rural area. This was also observed during the qualitative study, as most people in the rural area saw the low cost of living as positive to them. One male tutor aged 46 in the urban area said; ‘I would have loved to stay and work in the urban area, but the cost of living is very high, i cannot afford it that is why i am in the rural area’ (Rural nurse, R2).

The results further show that recognition has a positive and significant effect on employee choice of the rural area with a beta value (beta = 0.233), at a 99% confidence level ($p < 0.01$). While tutors in the urban area complained of not being recognized by their principals, those in

the rural area had a positive response. Most of them were of the view that principals knew them as key to the success of the school and treated them very well. One of the health tutors, who had moved from the urban area to join her husband in the rural area, said; I am very much happier here in the village than when i was in the city; my principal in the previous school did not respect us because there were many tutors there, but, in the village, here, tutors are scarce, so we are treated as essential commodities (Rural nurse, R15).

From the survey results, free accommodation has a positive and significant effect on employee movement to the rural area with a beta value (beta = 0.156), at a 99% confidence level ($p < 0.113$). This was also observed during the focus group discussion as most participants said the availability of free accommodation in the rural area was one reason for their choice to stay there. In supporting the idea, a newly posted male health tutor said; ‘I was told in Accra during the posting that, i will be given free accommodation if an accept posting to the rural area, as a starter in life, i wanted to save money by not renting’ ... (Rural nurse, R17). Most of the tutors in the rural area reported positively on being given free accommodation while those in the urban area were not given this.

As shown in Table 22 above, the inner desire to serve in the rural area was significant with a p-value ($p < 0.01$), at 99% confidence level, and the beta value of (beta= 0.136). Some health tutors in the rural area said they had a natural desire and love to serve in the rural area. Attesting to that, one of the tutors in the rural areas said; the inner feeling of being part of the rural people, helping them out of their problems and putting a smile on their faces is worth more than millions of cedis.

As shown in Table 22 above, it was also observed that no traffic has a positive and significant effect on employee interest to move to the rural area with a beta value (beta = .142), at a 99% confidence level ($p < 0.01$). One tutor said; There is no traffic light here, and therefore there is no traffic, everyone is free to move anyhow, no police to control human, bicycle, and car

movement, you can also use any route to school, and you are free... (Rural nurse, R18). From the results in table 14, p-value is not significant ($p > 0.01$), and the beta value of patriotic was negative (beta = -0.314). Therefore, tutors did not believe in moving to the rural area because of patriotism. This was, however, different from the focus group as some tutors said patriotism was one of the reasons for opting to serve in the rural area. One of the tutors said; As a patriotic citizen, i am proud to serve my country wherever my services are needed. Patriotism has to do with commitment and services to your nation (Rural nurse, R20).

Using survey question B6 to do statistical modelling based on the number of additional dependents shows that for each additional dependent in the urban area, a person is 1.8 times more likely to move to the rural area. A health tutor reported that she had to move to the rural area because of the considerable cost of living with a family of four children. She needed to do other extra work, and her government works to take care of the family, in Kintampo, Techiman, and Tamale, cost of yam, groundnut paste, tomatoes, et cetera are very cheap as compared to the city. It is tough to survive to live with four children with this meager salary (Rural nurse, R22). Other tutors who lived in the urban area, especially Accra, also expressed this perception. They showed the likelihood of moving out of the city to a rural area if life becomes challenging. Another finding from the research is that health tutors with higher educational qualifications, such as a second degree, are 3.970 times more likely to move to the rural area. One of the youngest vice-principals in the rural area said; Working in the rural area gives you lots of privileges, you are fully involved in work, you are allowed to voice out your feeling and also the path to headship or leadership is very close than in the urban area; if i were to be in Accra, i wouldn't have gotten the opportunity to head, some of my lecturers are still there and not even as Vice Principals but as tutors, being here is a privilege, and i prefer here than Accra (Rural nurse, R23).

From the research, 74.1% of health tutors in the middle age group (30-40) years would like to

move to the rural area if given allowances. During the focus group discussion, participants were asked, what would attract you to the rural area? Most of the 30-40-year olds said that providing them with allowances such as rural allowance, overtime allowances when you have worked for more than the stipulated 8 hours, and accommodation allowance would influence them to move to the rural area. One of the tutors in the urban area said; I would like to move to the rural area if the government introduces rural allowance and provide me with accommodation. Some countries pay staffs in the rural area rural allowances so Ghana can equally well do so.

Another tutor in the rural area who had applied for a transfer to the urban area said, “Master, I have applied for a transfer to join my family in the city, but if I am given money, I will convince them and stay in the rural area. Money is power; you know that it can motivate you better.” This is in line with the results, which showed that health tutors in the urban area who are not well motivated were 1.09 times more likely to move to the rural area than those who reported being well-motivated. To most of the health tutors, money was a key motivator. Therefore, they expected the ministry to provide them with additional funds, and then they would be motivated to relocate from the urban to rural areas. In my opinion, it is therefore vital that on the salary structure for health tutors, there should be a fixed amount allocated for tutors who agree to remain in the rural areas.

The final part of this section is taken from the in-depth interview of a past tutor to examine why health tutors move outside the ministry and where they prefer to move to when they leave the Ministry of Health. This will be done by applying a case study of two past health tutors who have left the ministry of health entirely, one from the rural, and another from the urban areas. Their stories will be supported by the Principal’s views and the survey results.

6.4 Departure from the Ministry of Health

As indicated in the methodology section of this study, the researcher proposed to include typical cases that depict and emphasize the phenomenon of interest. According to Yin (2012), “a case is a bounded entity (person, organization, behavioural condition, event, or another social phenomenon), but the boundary between the case and its contextual condition in both spatial and temporal dimension may be blurred” (p. 6). The cases that were selected and highlighted in this section focused on what Patton (2015) referred to as the exemplar of a phenomenon of interest (p. 273). Cases that are of exemplar of a phenomenon of interest offer insights into the phenomenon and stand alone as important. It is important to note that the exemplar of a phenomenon is cases that are purposely selected by the researcher to draw attention to the intrinsic value of the case (Patton, 2015).

The Ministry of Health training institutions has, for some time, now observed the internal movement of staff from rural to urban areas and from urban to rural areas in rare cases. The internal migration of health tutors is not as worrying to the Ministry of Health as some tutors remain in the ministry and move to where their services are most needed. Staff staying in the same ministry means the ministry of health has control over the staff and can deploy the staff to areas of needs. However, the most worrying situation is when staff is lost to other ministries, agencies, and departments. The worst of all is when staff migrates outside the country. This section of the chapter will tell a story of two past health tutors and a Principal. It will first look at the story of one male health tutor from the rural area called Wuseine, who was determined to serve his people in the rural area and promised his Principal that nothing could move him out of the rural area. However, the unexpected happened. After a few years of teaching, he had to give up and move on in life despite his promise to the Principal. This case exemplifies how circumstances in the rural area can change even avowed tutors who pledge to stay in the rural area come rain or shine.

The second case study will examine a female tutor called Sandra from the urban area who was so excited to have been appointed a tutor in the urban area. She was fortunate to be given a car by the ministry as motivation and pay for it by installment. This arrangement was made by the Principal of the school to keep her as the only midwife in the school to offer support in teaching. Because of the car and the essential nature of her service, she was convinced to sign a bond to teach for five years in her school, which she gladly accepted, but unfortunately, she had to leave after serving for only two years. What could be the cause? The final section will focus on the story of a Principal who has worked in both the rural and urban areas for several years. She will finish by telling us of her experience, why health tutors leave the Ministry of Health.

6.4.1 Wuseine's reflection on why he left

Wuseine was born on the 19th of January, 1981, and is the first child of his parents and had three siblings aged 14, 16, and 18 years. His colleagues, community members, and family popularly called him Kwaku Ananse. The name Ananse in Ghana is a spider, but he is also a person with more wisdom than the average human being. He is mostly seen as intelligent and a trickster. In Ghana, most people give names to their children hoping that they will fulfill the meaning of the name. Friends and family members also give nicknames based on a person's lifestyle and behaviour. In this story, we will see that friends and family nicknamed Wuseine as Ananse because of his lifestyle, which he transferred to the worksite (Past rural nurse, PRN 1). Ananse, as affectionately called by friends, did a degree in nursing but had no work or clinical experience. For three years, he had sat in the house looking for a job, to no avail. As a smart young man with the characteristics of Ananse, he went to the MoH and said that he was ready to serve in any part of the country, especially the most remote area. He told the ministry that his choice of the remote area was because he wanted to serve the underprivileged, the rural poor who needed his services. Fortunately, for Ananse, his story was good news to the ministry,

so he was posted immediately to the rural area to start work. Again, at his new post in the rural area as a smart young man, he told his Principal that he was not ready to move out of this school, although it was located in the rural area. He told the Principal that he wanted to help him develop the school, and after ten years of service, he might then consider moving. The Principal was so excited and did all he could to make Ananse very happy. The Principal actively includes Ananse in school activities; he was core to his administration. Not known to the ministry and the Principal, Ananse only needed some work experience to advance his career. Ananse, having stayed in the house for long without a job, and being the first son of the family, had to find ways to find a job to support the family; not because he wanted to serve the underprivileged in the rural area.

After serving for three years and having gained experience from the school, Ananse now wanted to experience conditions outside the ministries of health and earn more money based on his experience of work in the ministry. He then applied to one of the organizations in the city, which gave him an offer of twice his salary, and other conditions. The finding from the in-depth interview concurs with the results from the survey question E7. Some tutors accept employment in rural areas to gain experience and, in turn, apply for “better” jobs outside of the ministry that will increase their salary (25%) exponentially. This action supports the story of Ananse mentioned in the previous chapter.

Table 23: Reasons for wanting to move from MoH training institutions, tutors from the rural area only (N= 158)

Reason	Frequency	Percentage
Money	39	25
Work conditions	14	9
Free accommodation	16	10
Promotion	19	12
Recognition	26	16
Outside MoH experience	44	28
Total	158	100

Source: Survey, 2016.

Ananse had difficulty telling the Principal about his new employment, so instead, he told the Principal his father has fallen ill and admitted to the hospital in the city. Therefore, he must leave immediately to attend to his ailing father. The Principal decided to offer him a car and a Driver, but Ananse rejected it and gave a simple reason that he would cope with public transport. After one week without any form of communication, the Principal became alarmed and tried calling Ananse. However, Ananse's phone was off and has been off until now. However, I was later able to locate Ananse, and in the interview with Ananse, who is now a past health tutor, he said; Ghana is like a jungle, and it is the survival of the fittest. I had to use my brains to get work to gain work experience and support my siblings; where do employers expect me to get work experience if no one employees me. (Rural Allied health, RA9). Interviewing him on why he left the job, he said, "he was fed up with the rural life"; he needed

better pay and experience outside the ministry of health, and he could not wait for ten years as he had promised the Principal.

This finding supports the survey results, as gaining work experience outside the ministry of health (28%) was highly significant in determining health tutors' who work in a rural area having the intention to leave the Ministry of Health. The results from the survey also show that money (25%) was also an essential factor for health tutors to leave tutorship in the ministry of health. Others are recognition (16%), promotion (12%), free accommodating (10%), and work conditions (9%).

6.4.2 Sandra's reflection on why she left

(Past urban nurse, PUN 1). Sandra, a past health tutor, was born on Wednesday in Accra, the capital of Ghana. In Ghana, all females born on Wednesdays are called Adwoa. Adwoa attended primary, secondary and tertiary institutions in Accra. The furthest she has traveled is Kumasi, the second biggest city in Ghana. Sandra did a diploma in midwifery with the MoH training institution, was employed by the MoH in Accra to work for five years, which then qualified her for further studies. Still, she only served for one year and continued to do a degree in midwifery. As she did not serve her bond period of five years after the diploma program, her name was taken off the payroll, and she was not granted study leave. After completion of her degree program, it was tough to get work in the city, but there were vacancies in the rural area for her. She, however, was not willing to work in a rural area. Fortunately, she met a Principal at a career fair looking for a degree midwife to teach in her school. The school is in the urban area, which was the wish of Sandra. She readily accepted to start work without authorization (financial clearance) from the MoH headquarters. The principal of the school kept putting pressure on the ministry to grant Sandra financial clearance, which was given six months later.

She was given the financial approval despite not serving the bond period because the bonding system is weak and sometimes was based on whom you know.

The Principal gave Sandra a salary advance for accommodation and guaranteed a vehicle from the ministry to make Sandra happy. The amount was to be paid in installments. Sandra was so excited that she told her Principal that her wish was for an urban school, and fortunately for her, the school is in the capital where she has access to social amenities. Her other dream was to find a man of her choice to marry and settle down. Sandra assured the Principal that she had nowhere to go and would offer the best of sacrifices since the Principal had been so good to her.

Two years later, Sandra's prayer of finding the right man was realized, and she got married to a young Ghanaian who was resident abroad but came for a visit where he met Adwoa. They got married, and she gave birth to a baby girl a year later. One day, the Principal was in her office when Sandra came with the husband, their humble plea was to thank the Principal for her kind gesture, but unfortunately, she had to leave with her husband to go abroad. The husband could not cope with the cold weather, washing, and cooking, so there was a need to go with her husband.

Sandra is currently in Germany, and in a snowball interview with her, she said the main reason she left the ministry of health training institution was two-fold. The first was a marital reason, and the second was being rewarded as a nurse abroad, which served as a motivation factor. She claimed she earned four times her Ghanaian salary abroad. This also correlates with the survey results in table 16 obtained from E8, as money (30%) was highly significant in determining whether health workers' would stay or leave the ministry of health. Other essential factors in deciding if a tutor in the urban area will leave tutorship in the ministry of health include right work conditions (22%), promotions (20%), free accommodation (11%), outside MoH experience (9%), and recognition was the least important thing for the urban health tutor.

Table 24: Reasons for wanting to move from MoH training institutions, tutors from the urban area only (N=171)

Reason	Frequency	Percentage
Outside MoH experience	16	9
Work conditions	38	22
Free accommodation	19	11
Promotion	35	20
Money	51	30
Recognition	12	7
Total	171	100

Source: Survey, 2016.

6.4.3 The principal

(Principal Urban/Rural, PUR 1). From section A of KII question 4, 12-14, this researcher confirmed that principals interviewed worked for 18 years in the rural and urban areas. The principals said she believes she was in the best position to tell why most health tutors leave the ministry of health to other agencies or ministries.” These were the words of Aberewa, a 58-year-old Principal who has only two years to go before retirement. *Aberewa*, in Ghana, means the old lady. It is a belief that an old woman is full of knowledge, and it is common to hear people in Ghana say, ‘let me consult the old woman,’ meaning let me consult the knowledgeable woman who is an adviser.

According to Aberewa, she has served diligently as a tutor for 20 years; she rose to the rank of deputy chief health tutor and therefore was qualified to head an institution. In her first interview for principalship, she competed with her seniors, who had only two years to go before retirement. She was the best candidate in terms of the interview results. Still, culture played a part in letting the ministry give the Principal's position to the most senior person with experience. In her second interview for a principal's post, she was determined to use any means, be they cultural or political, since, according to her, these were the most common ways to get a position. Using her political connection after the interview, she saw her member of parliament, who was also a minister of state, to lobby for her.

Life as a tutor and as a principal has been quite challenging, especially in a leadership position. The issue of both internal and external migration was related to individual characteristics and the current corrupt practices in the ministry. According to her, 40 years previously, selection into the profession was based solely on the love for the job. The selection was based on people who wanted to serve the sick, the poor, the underprivileged, and the needy. It was a noble profession seen as a divine call to serve humanity. Irrespective of where you were posted to, you accept the posting because you love the job, and you are willing to work at any place you are sent. Twenty years down the line, politics, tribalism, nepotism, and monetization started playing a role in selecting students into the profession. The selection was no longer based on love for the job. Health tutorship has become a profession for the privileged in the society, the rich, and the elites. People who have the desire to serve but do not know anyone to lead them or seek for protocol end up being rejected, and this is one of the main reasons for both internal and external migration. The Principal intimated, if one has paid a bribe to enter into the profession, definitely such a person will want to recoup his/her money after training. Therefore, any agency that offers more than the Ministry of Health will entice the person away. The profound love is lost and replaced by money.

One key thing she also stressed was the mode of selection into the health training programs. According to her, our selection process should be the fundamental point to start correcting the migration problem. Selection should be free and fair, irrespective of creed or social status. It should be based on love for the job and willingness to accept posting to any part of the country after training.

Another thing she mentioned is the need to enforce the policies of the ministry, irrespective of whom you know or social status. The Ministry of Health policy document states that every individual who has completed the MoH training institution and has been absorbed by the MoH is expected to serve a minimum of three years in the rural area, or five years in the city before leaving the service. These laws were strictly adhered to in previous years when she started her profession, but now, it is not. People with political fathers and relations do not abide by these rules and regulations, and nothing is done to them. The policies of the ministry should be strict, fair, and firm. No one is above the law. Stressing the status of the health tutor, she said conditions in the MoH are now better than in her time. Therefore, young people who are currently taking up various positions in the service should appreciate the work of the government amid scarce resources.

CHAPTER 7

INTERPRETATION AND DISCUSSION OF FINDINGS

7.1 Introduction

Throughout this thesis, the researcher emphasized investigating factors that influenced health tutors motivation and retention in selected health training institutions in Ghana from both the northern and southern parts of the country. My intention in researching this particular area of study has been to inform evidence-based motivational-retention policy for health tutors in Ghana and showcase the clear-cut difference between the health worker in the clinical area and the health tutor. The key findings of the study are discussed within this chapter: this involves integrating findings from the literature review and the primary research findings.

The first section will seek to interpret the findings of the results and its implication for theory and the literature. This will be followed by discussing the background conditions and circumstances that lead to individuals making choices regarding working as health tutors followed by an exploration of the health tutors perception of equity at the workplace. Are health tutors being treated fairly at the workplace? The chapter will then examine separately the health tutor motivation followed by the health tutor retention. The section will then conclude by investigating the connection between motivation and retention.

7.2 Interpretation of findings

The finding of this study shows that money is the primary driver of motivation among health tutors in Ghana, confirms the assertion of Herzberg, Mausner and Snyderman (1959) that hygiene factors such as work conditions, remuneration, salary, and security are related to physiological needs of man. The health tutors can be said to be at the level of satisfying their most basic needs of food, safety, and security, whether they are working in the rural area or urban area. It would be proper to assert that the health tutors of Ghana are extrinsically

motivated because the nature of extrinsic motivation is that its purpose is to achieve some reward (Legault, 2016). Extrinsic motivation looks for rewards in monetary and material prizes such as bonuses, benefits, and promotions (Legault, 2016; Singh, 2016). For health tutors in rural and urban areas alike to prioritize money as the primary motivator of work means that their most pressing physiological, safety, and security needs transcend geographic location. The emphasis on money is an indication that health tutors perceive their compensation packages in the form of salaries and remuneration as inadequate and unsatisfactory (Lumley et al., 2011).

The finding that health tutors in the rural areas are motivated by encouragement and moral support for the work they do, while those in urban areas are interested in accommodation can be interpreted to mean that satisfaction of the most pressing need is a driver of motivation. For health tutors in rural areas, beyond money, their most pressing need is to be encouraged and given moral support. Maslow's hierarchy of needs framework can be used to explain this need succinctly. According to Maslow (1970), the human being has levels of basic needs starting from physiological needs, followed by safety and security needs, and then satisfactory associations with others, including belonging to groups, giving and receiving friendship and affection. The need for encouragement and moral support from peers and supervisors can be equated to Maslow's third level need for giving and receiving friendship and affection. This means that health tutors in rural areas have their physiological and safety, and security needs met hence the drive to build on their self-efficacy through verbal persuasion. With regards to the urban health tutors focusing on the need to be motivated by accommodation can be interpreted to mean that they have challenges with meeting their safety and security needs. Using Maslow's hierarchy of needs framework as a framework, it would be proper to interpret urban health tutors' need for accommodation. Using Herzberg's motivation-hygiene theory as a framework for the interpretation of the finding, the need for encouragement and moral support

by rural health tutors is positive and therefore is a motivator that would produce satisfaction. Since encouragement and moral support are motivators, even when this need is not satisfied, it will not create dissatisfaction among rural health tutors. On the other hand, the need for accommodation is a hygiene factor that tends to produce dissatisfaction among urban health tutors when it is not satisfied (Herzberg, 1959).

The finding that health tutors in rural areas are engaged in constant social comparison by comparing their inputs and outputs with those of their counterparts in urban areas indicates a disparity in the output they receive. As explained by the equity theory, health tutors, especially those in rural areas who are unable to rationalize the inequity that they suffer to end up adopting one of the three strategies of reducing feelings of inequity. First, they try to increase their outcomes by seeking increased benefits, such as raises in remuneration and salaries. If the first measure does not work, they try to reduce their inputs by expending less effort on the job, such as not teaching and not marking students' examination scripts. The last strategy is to leave and find another job. The third strategy of moving and finding another job is commonly associated with health tutors in rural areas because they compare their inputs and outputs with those in urban areas.

From F6 of the survey questionnaire, health tutors were asked, when they compare to others do you think they are being treated fairly? The perception by 63% of health tutors that the Ministry of Health does not equitably treat the inputs they provide compared with the outcomes they are given is an indication that the Ministry of Health is not sufficiently motivating health tutors for the work they do. As indicated in the literature review section, compensation packages affect motivation (Bohlander et al., 2001; Marlow et al., 1996). Where workers perceive that their remuneration and salaries are low, their motivation to work decreases. The high belief perception (63%) among health tutors that the Ministry of Health is inequitably treating those means that a large proportion of health tutors are adopting one of three strategies

to cope with the perceived inequity. The belief further elaborates on the survey question F3 (What do you sometimes compare with the others), health tutors did confirm that they compare their inputs and outcomes ratios to others. The meaning of these two crucial perceptions among health tutors is that they are either agitating for increased compensation packages, or expending fewer efforts on their jobs, or leaving the teaching job to find employment elsewhere.

7.3 Implications

This study is significant in several ways. The attraction and retention of health workers in remote and rural areas have practical, policy, and decision-making implications. Personal and family factors, working and living conditions, career-related factors, and issues relating to compensation packages contribute to the decision of health workers going to work in rural areas (Henderson & Tulloch, 2008). The findings of this research study have possible implications that could give direction to the Ministry of Health in Ghana regarding how to motivate health tutors in both rural and urban areas. This research reinforces the 2016 World Health Organization report that stated, among other things that, the availability of health workers must include their equitable distribution and accessibility to the entire population, the possession of health workers of required competency, appropriate motivation, and empowerment to deliver quality service that is appropriate and acceptable to the sociocultural expectations of the population (WHO, 2016). The findings of this research study also have implications for decision-making and the scholarly literature on health tutor motivations.

7.3.1 Implications for Theory and Literature

As noted from Chapter 4 through Chapter 7, the findings of this research study were reflective of the topical and theoretical scholarly literature that was reviewed in Chapter 2. Regarding the topical literature, the findings of this study were in alignment with the literature on worker

motivation, retention, and issues equity. Human resources is an invaluable asset, and for any organization to attain its goals of performance, its workers must be motivated. Considerable attention has to be paid to satisfying workers through incentives, rewards, prevailing circumstances at the workplace, and leadership (Armstrong & Taylor, 2020).

Regarding motivation, this study has theoretical implications for Herzberg's motivation-hygiene theory. According to Herzberg (1959), hygiene factors (company policies, supervision, relationships, work conditions, remuneration, salary, and security) are linked to the dissatisfaction of workers. Remedying the dissatisfaction of worker needs does not create a sense of satisfaction, nor does it necessarily enhance performance. However, in this study, Ghana health tutors asserted that money was a satisfying motivator that would not only create a sense of satisfaction and peace at the workplace but also be a catalyst for enhanced work performance. This finding departs from Herzberg's motivation-hygiene theory, which asserts that both motivators (achievement, recognition, the work itself, responsibility, advancement, and growth) and hygiene factors were linked to worker dissatisfaction are all remedied before there can be worker increased performance and satisfaction. Based on the findings of this study, it seems that the cultural interpretation of money as the primary source of motivation does not apply to Herzberg's two-factor theory of motivation.

The decision by dissatisfied health tutors to leave their jobs in the rural areas for lucrative ones in the urban areas has implications for creating retention management systems in the Ministry of Health in Ghana. Employee retention, according to James and Mathew (2012), is a step taken by organizations and managers to encourage their employees to remain working with them for a considerable number of years. The Ministry of Health in Ghana needs to devise retention management systems for its health tutors, particularly in the rural areas of Ghana. According to Yazinski (2009), identifying and valuing employees experience and achievements, for instance, is an effective strategy to enhance retention in the organization. The advantages of

employee recognition are priceless. Studies buttress that verbal praise alone can promote organizational loyalty, positive behaviour, motivation, confidence, teamwork, ethics, and employee growth (Redington, 2007).

This study has implications for promoting equity among health tutors in Ghana. Equity in the workplace is essential to ensure that workers input matches with the wages they receive for their efforts (Budd & Colvin, 2008). The perception and belief among health tutors in the rural areas that their inputs are not equitably rewarded require that the Ministry of Health design reward and worker motivation systems capture the socio-economic conditions of the geographic areas where its workers reside. Promoting equity in every part of an organization can increase productivity (Okun, 2015). According to Braveman and Gruskin (2003), “Equity means social justice or fairness; it is an ethical concept, grounded in principles of distributive justice” (p. 254). Equity in the workplace and the opportunities provided by an equitable organization drive individuals to achieve (Dugguh & Dennis, 2014; Kundu & Mor, 2017). Thus, when employees realize that their efforts are given appropriate acknowledgment and that rewards match or agree almost exactly with their efforts, they are motivated to give out their best to achieve their target (Dugguh & Dennis, 2014; Wiley & Kowske, 2011).

7.4 Limitations

Limitations of a study are the weaknesses in the methodology that are outside the control of the researcher (Roberts, 2010). While there are no defined rules for sample size, sampling in qualitative research relies on small samples to provide rich and in-depth data (Patton, 2015). Instead of using random sampling to generate a representative sample, the sample is limited to a purposeful choice of cases deemed rich with information on the issue being studied (Ezzy, 2002). The limitation associated with the quantitative segment of this exploratory sequential mixed methods study was survey instruments. The researcher did not have control over the

personal and environmental conditions of the participants as they completed the surveys. The availability of time to complete the surveys by research participants affected the overall responses. There is the probability that the survey instruments, although randomly distributed, may not be an accurate representation of all tutors' views across Ghana. And therefore, limit the ability of the findings to be generalized to the entire population of tutors in training institutions in rural and urban areas of Ghana. Finally, the scope of the research, due to time and resource constraints, was limited to only one rural and one urban area of Ghana.

7.5 Discussion

Chapter 4 reported three significant findings related to health tutors background conditions and circumstances that lead to individuals making choices to work as health tutors. These were the economic, cultural, educational, emotional, and social backgrounds of health tutors; the influence of school and Ministry of Health administration; and the role of the school environment.

7.5.1 Health tutors economic, cultural, educational, emotional and social background.

From the findings in this research, it was observed that health tutors' motivation to teach and to remain in the classroom was influenced by their personal experience, education, family, culture, and life experiences. In similar studies conducted elsewhere, responses have varied and often tied to a person's economic, social, and emotional situation when making this decision (Eick, 2002; Chan, 2004; Muller et al., 2009; Nevin et al., 2009). This assertion supported the views of the Principal of Aberewa in chapter six, which noted that it is essential to look at the person's background and interest for the job, not the social status of the individual. The background is influential in ensuring that the right health tutors are placed in the right place. My results also showed that health tutors who joined the profession due to the belief that

God's calling tends to report that their desire for the job is to help others, show love and care. These findings agree with a similar study conducted in Australia among nursing students, which showed that the decision to join nursing was due to their desire to help others, care for them, and show a sense of achievement and self-validation (Newton et al., 2009). The finding was further confirmed in a study conducted in Kenya among public health workers showed that their desire to join the profession was to help others and self-esteem (Mbindyo et al., 2009).

7.5.2 Influence of training institutions and the Ministry of Health Administration.

School administrators may have critical answers to the challenge of low retention among health tutors if they consider what motivates teachers to enter the profession, identify, and address teachers' needs early in their career. In this study, there were mixed feelings of good and bad experiences from tutors about motivation. Some tutors emphasized the primacy of recognition from the school administration or the Ministry for their contribution to service. As reported earlier on, recognition had a positive and significant effect on employee choice of the rural area. While tutors in the urban area complained of not being recognized by their Principals, those in the rural area had a positive response. Most of them were of the view that Principals knew them as key to the success of the school and treated them very well. As seen in chapter five, Panin, a health tutor who had moved from the urban area to join her husband in the rural area said, she was happier in the village than when she was in the city; her Principal in the previous school did not respect the tutors there because there were many tutors in the school, but in the village here, tutors are scarce, so they are treated as essential commodities. It is therefore important that the school administration identify the factors that can contribute to the health tutors motivation and retention. Several studies have highlighted the importance of administrations identifying factors that contribute negatively to teachers decision to remain to teach or leave teaching altogether. Some of the positive things expected from school

administrations and the Ministry of Health to retain health tutors do not involve cost. My findings reinforce a broader perspective on the role of positive non-financial factors, such as respect for employees. These findings concur with that of Campbel et al. (2012). They argued that non-monetary benefits are an area that could lead to employee dissatisfaction leading to an employee leaving a job. In focus group discussions, a few health tutors said their motivation to stay was strengthened by respect from students, colleagues, and society, among others. Rural tutors frequently shared that most of the students respected them, and that was one of the things that motivated them to stay.

My research identified some perceived unreasonable demands of the schools that could cause a tutor to resign from the establishment. This includes the tutor's work overload, which extended even into the weekends, thereby affecting tutors' work-life balance. 63% of the health tutors reported working between 9-12 hours a day, which could sometimes be demotivating. Daly and Dee (2006). Heavy workloads, including assignments to teach large classes, generated hostility towards the organization and diminished levels of faculty commitment to the institution and retention, made similar observations.

The considerable workload on health tutors have implications for the study. In Chapter 1, the study noted that the health tutors role was not only to teach but also to undertake research, fieldwork assessment of students, alongside a range of other scholarly activities, fulfill administrative functions, and, in some instances, support staff in the clinical area. These roles are varied and demanding in scope, taking away much of their time on weekdays and weekends. Instead of health tutors working for eight hours a day, from survey question B14, most health tutors (63%) in the rural area work up to 13 hours a day. This could be due to short commuting time observed in survey question B11 as the average commuting time for a rural worker in a day is 10 minutes while that of those in the urban area is 38 minutes Working long hours affects their work-life balance and has clear implications for wellbeing (Lawson, 2010). According to

the Ministry of Health, health tutors are either general nurses, midwives' community health nurse, environmental officer, laboratory Technician, and disease control officer, but does not include the physicians. The person should have a background in health and should have practiced for a minimum of three years in the clinical area and has a minimum of a first degree plus a certificate in education to enable the person to teach (MoH CHPS Policy Guide, 2015). Unlike the other health professional in the clinical area who could practice with a diploma and only serve on the clinical side, the health tutor is expected to have a minimum of the first degree. The teaching is expected to take part in clinical work. Compared to other health workers who teach at university as lecturers, which is under the ministry of education, the lecturers are paid research allowance, book allowance, accommodation, and others. In contrast, the health tutors with the same qualification do not enjoy research allowance, book allowance, accommodation (MoH, 2015). It is, therefore, necessary to look at how best to reduce some of the workloads from the tutors.

7.5.3 Role of the School Environment

My research found that most health tutors (67%) regard the school environment support systems critical in deciding to stay in a school. Several tutors believe that an excellent supportive environment motivates a teacher to be retained. According to Koko, in chapter 4, it was the school support system accompanied by the collegial respect she received, which led Koko toward remaining in tutorship. A supportive working environment aligns with the literature, which indicates that people enjoy working and strive to work in those organizations that provide a positive work environment. They feel they are making a difference and where most people in the organization are proficient and pulling together to move them forward organization support (Milory, 2004). Workspace designs have a profound impact on workers, and they tend to live with a job if satisfied (Brill, Weidemann, Olsen, Keable & Bosti, 2001).

After examining the surrounding conditions and circumstances that lead to individuals choosing to become health tutors, the next section discusses the health tutors' perceptions of equity and inequity at the workplace

7.5.4 Equity and Inequity at the Workplace

“It is not fair”, “you are not fair”, “he is not fair to me”, are common phrases in discussion in Ghana and were in evidence frequently in interviews with study participants. The Standard English dictionaries list “justice” and “fairness” as synonyms. The literature review indicated justice and fairness encompass virtues such as moral rightness, equity, honesty, and impartiality. Throughout my study, fairness or justice was one of the most fundamental concerns of health tutors. Cohen (1986b) claims that justice is “a central moral standard against which social conduct, practice, and institutions are evaluated.” Injustice is directly harmful to employees' psychological health and well-being. It contributes to stress (Greenberg, 2004), and therefore managing workplace stress by promoting organizational justice is very helpful to organizations (Tepper, 2001).

This study found that many health tutors are conscious of equities and inequities present in the workplace. Nearly three-quarters of tutors (73%) believed in the theoretical perspective of equity and compared their work input-to-output ratio to others. Through comparisons, these tutors decide whether they are experiencing a situation of equity or inequity at the workplace. There is a substantial minority of health tutors (27%) who do not use the principle of equity in this way. One of the tutors from this group stated that comparing yourself to others at the workplace in terms of input: output ratio is like comparing apples to oranges. In his view, when people are working in different socio-cultural situations, each one has a different aim and objective.

The literature review identified three types of equity: external, internal, and employee equity (Konopaske and Werner, 2002). The literature emphasized how individuals compare themselves to others. Some use a point of reference from the work side, which is termed internal equity, while others compare themselves to others outside the organization. A critical finding from this research work related to equity is the external comparison of the health tutors' salaries to others in the Ghana education service. As portrayed in chapter five, employees in the health training institution compare themselves to others who have the same job but are employed with the Ministry of Education.

The research indicates that a higher proportion (63%) of the health tutors in the Ministry of Health feel that their substantial input is not reflective or depicted in the outcome or benefits they obtain. In comparing themselves to employees of the Ministry of Education, they feel there is an imbalance in the distribution of benefits given for work completed, and they are not treated fairly by their employer, the Ministry of Health. The Ministry of Health should pay close attention to the practice of distributive justice to eradicate any sense of injustice, unfairness, or resentments that might develop within its staff members, thereby causing high rates of turnovers and lack of motivation. It would be in the Ministry's best interest to demonstrate a sense of empathy and thoughtfulness towards their staff. When the Ministry of Health empathises with staff, they will be motivated enough to work and erase the mindset that the ministry does not care about its staff well-being. This is also necessary to motivate the health tutor to stay in tutorship and to deliver their best at work.

One other notable finding related to equity is staff promotion, from survey question D4 (Possibility for promotion). A higher proportion of the health tutors (63%) ranked promotion as very important. Still, it was disappointed in the procedure with which information on promotion and other essential facts on tutors were circulated. Some tutors confirmed the inherent problems at the central level, and its policies on staff welfare and promotion allowing

mostly urban schools to be provided with vital information before their rural counterparts portray the lapses in the system, which is part of the procedural justice. Therefore, the process entailed for the health tutor to determine job promotions are inefficient and requires significant changes. For example, there should be fair procedures that allow all health tutors to have equal access to vacancies for promotions, study leave, travel abroad and other benefits. When people do not get the rewards they want, they tend to hold management responsible if procedures are not fair (Brockner et al., 2007). My literature review identified many ways of achieving equity. For example, giving employees *advance notice* before laying them off, firing them, or disciplining them is perceived as fair (Kidwell, 1995). It is therefore vital that advance notices on staff promotion and other benefits be sent to health training schools on time. Advance notice helps employees get ready for the changes facing them or allows them to change their behaviour before it is too late (Alge, 2001).

Finally, in terms of equity of posting, it was observed that only one-third (33.9%) of health tutors from the rural area requested for posting to the rural area. However, two-thirds (66.1%) of the health tutors were posted to the rural area by the Ministries of Health. Contrary to that of the rural area where only a few requested posting to the rural area (33.96%), the majority of the health tutors in the urban area (70.8%) personally requested for posting to the urban area while a few (29.2%) were posting to the urban area by the ministry of health. This reflects the unequal treatment of health tutors, as noted in chapter 4 by some health tutors as to others who had the privilege and chance to select their posting. Most of those who had the chance to choose their posting decided on the urban area. This reflects the national disparity in terms of the wide rural-urban disparities in the distribution of human resources in Ghana. Over 70% of medical practitioners, nursing professionals, pharmacists, and dentists work in urban areas (GHWO, 2016).

In conclusion, all tutors are treated equally irrespective of location. Opportunities for promotion, posting, and further training should be provided for all staff. Since employees tend to compare their input and output ratios with colleagues, they should be motivated through equal treatment (Cole, 2002). Others might not decrease their work input but opt to leave the institutions to other places they feel they will be fairly treated.

7.6 Health tutor motivation

According to Kanfer (1999), motivation is an individual's degree of willingness to exert and maintain organizational goals. In other words, the term is conceptualized to be a set of psychological processes that influence workers' allocation of personal resources towards those goals, affecting workplace effectiveness and productivity. The findings from this study confirm distinct issues related to motivation in each of the two settings, rural and urban). According to the tutors, motivation is an individual phenomenon; it is multifaceted, and that the purpose of motivational is to drive behaviour Schultz and Schultz (2010). However, from the survey, one in two tutors from urban areas thought that motivation was primarily an issue of money. A similar trend was observed for those from rural areas, with one-in-three tutors perceiving motivation as only money. These patterns for urban and rural areas were not significantly different. Health tutor from both rural and urban areas frequently reported that motivation drives the action of an individual towards work and that the drive and action towards work depend on the money you give them. A good drive or motivation means the right amount of money to push them to work hard for the organization. Money to them formed an inducement, which was synonymous with motivation, and therefore providing health tutors with money aside their salary would motivate them to stay in any part of the country where there are health training institutions.

The categorization of motivation as extrinsic or intrinsic is of clear relevance here. From outside the job, extrinsic motivation indirectly satisfies the lower-level human needs associated with basic survival and includes financial rewards, working conditions, and job security. From within the job, intrinsic motivation results from satisfying the higher-level human needs (Franco, Bennett, et al. 2002). This includes job satisfaction, compliance with standards for their own sake (e.g., ethical standards, fairness, and team spirit), and the achievement of personal goals (Frey and Osterloh 2002). When tutors were asked the motive behind tutorship, some health tutors (28%) said the inner joy and satisfaction they received from teaching and their interest to serve as their primary motivation. According to the minority, money is not the main reason for accepting the job, but the interest in the position is the prime reason for taking the job. This is in line with the literature, which says the inner feeling for the job is related to intrinsic motivation (Franco, Bennett, et al. 2002). There are others whose motivation for the position of tutorship is derived from money. Those who think of money as a motivation fall within the intrinsic aspect of motivation.

It was observed from the studies that there is a tendency for money to change or influence the individual desire for the intrinsic to extrinsic reward. Some tutors who had a strong inner passion for teaching further asserted that money could be a pivotal factor in transferring to another school that provides more allowances to teach. In this case, the tutors were not comparing their benefit to that of the other colleagues but asserting that additional financial gain could influence them as a motivational tool to move to another school. This supports the findings of Deci (1995) that “when money was used as an external reward, intrinsic motivation tended to decrease.” If tutors feel other institutions provide them with additional incentives, they are most likely to be motivated to move there. Evidence in the health sector might be limited, but several socio-psychological experiments have shown that, under certain circumstances, there is a trade-off between intrinsic and extrinsic motivation (Deci and Flaste

1995; Frey and Oberhozer-Gee 1997; Gneezy and Rustichini 2000a; Gneezy and Rustichini 2000b). This research found that some tutors have the inner desire to teach and love the work itself. Still, the introduction of money at other schools or other agencies such as the university tends to shift their interest of teaching in the ministry of health school to more of incentives, reward, or money at the university.

7.7 Health tutor retention

Multiple factors influence a health worker's decision to relocate, stay, or leave a post in rural or remote areas. They are sophisticated and interconnected factors linked to health professionals characteristics and preferences related to health systems organization and broader social, political, and economic environment (WHO, 2010). From the research. It was observed that health tutors inner desire to serve in the rural area was significant with a p-value ($p < 0.01$), at 99% confidence level, and the beta value of (beta= 0.136). Some health tutors who were in the rural area said they had a natural desire and love to serve in the rural area, not because of money but service to humanity. They believe that they are more satisfied when they offer services to the people who are in the rural area because they are underserved, impoverished, and limited social amenities, so those are the areas their services will be much needed. This is in line with research conducted in Ethiopia and Rwanda, which has identified that helping the poor is one of the motivation factors that encourage health workers to serve the rural communities (Serneels et al., 2010). Interviewed health workers in Malawi mentioned that assisting humanity is one of the motivation factors to stay in the profession (Manafa et al., 2009).

In Training and Development, multiple factors influence a health worker's decision to relocate, stay, or leave a post in rural or remote areas. They are sophisticated and interconnected factors linked to health professionals' characteristics and preferences related to health systems

organization and broader social, political, and economic environment (WHO, 2010). Although these factors are context-specific, the evidence from different countries suggests a standard set of issues that vary in their combination and degree of intensity. Commonly reported factors include inadequate pre-service training for rural and remote areas practice, lack of opportunities for further training, and career development (Grobler et al., 2009). While economic factors play a crucial role in the motivation and retention of health workers (Henderson and Tulloch, 2008), other factors are equally important. For instance, many health professionals in Ghana often leave deprived communities or districts due to limited opportunities for additional training and career advancement, lack of access to quality education for their children, and the absence of more desirable working conditions in the hospital (Manongi et al., 2006). This in-country migration, rural to urban as well as emigration of health workers in Ghana, inevitably further deteriorates the poor, rural, and deprived area's plight and lessen access to quality healthcare. The effect of all forms of emigration influences the health system's performance, including maternal and child health indicators, which correlate with health worker density (Chen et al., 2004). This was also observed in the research as shown in table 3 above, training and development have a positive and significant effect on employee choice of location in the urban area with a beta value ($\beta = .123$), at 99% confidence level ($p < 0.01$). Tutors who opted to be posted to the urban area from the rural area said there were more opportunities for further training and development in the urban areas, where there are institutions of higher education. From the literature review, it was observed that several factors influence the decision of health workers to stay in or leave their posts. One of the keys challenges of retaining health workers in rural and remote areas is because health practitioners in these areas often face higher workloads and poor infrastructure, causing them to leave the workplace in search of more satisfactory working and living conditions in urban areas. This is in line with the study findings from the focus group discussion that most of the tutors in the rural areas complained about the

immense workload. This was also one of the reasons given by the researcher for his interest in the study using himself as an example as a former tutor in the rural area. There were a few tutors, a considerable workload, and limited teaching and learning apparatus to utilize. Also, from the survey question D10 (Availability of adequate modern facilities in this institution), it was observed that health tutors from the rural health training institutions were very disappointed in their facilities. The rural schools have poorly equipped clinical sites and underdeveloped infrastructure compared to the old existing schools in the cities with big teaching hospitals for clinical sites. Therefore, tutors in the rural areas sometimes have to improvise during clinical times, and due to the lack of appropriate devices, some of them end up leaving the institutions to other places that they perceive are well equipped. This observation was supported by a study conducted by Willis-Shattuck et al. (2008), which revealed that health workers complained of working without standard equipment such as a microscope, which was a source of de-motivation. Access to resources at the workplace is not only a requirement for providing excellent quality health services, but it is also a factor stimulating the workforce (Willis-Shattuck et al., 2008; Henderson and Tulloch, 2008). Modern working equipment creates a much more stimulating work environment than working with dilapidated equipment. Mather and Imhoff argue that the shortage of supplies and resources is a considerable challenge at many health facilities, particularly in rural areas in Africa (2006).

Across this study, the likelihood of someone with a degree leaving the rural area to be urban is seven times more likely than someone with a Master's degree. Most people with a degree will prefer an opportunity for further studies and excellent social amenities (Lori *et al.* 2012). Tutors, who had a Bachelor's degree, prefer to move to the urban areas where there are many opportunities for further studies to do their Masters. However, after completing the Master's degree, they prefer to move to the rural areas where there are vacancies for tutors with a Master's degree to head institutions. Health tutors with a second degree are four times more

likely to move to the rural area. The chances of becoming a Principal or a Vice-Principal was more likely in the rural area with a second degree than in the city, as seen in chapter 4. This is one of the differences between the general health worker and the health tutor. The general health worker mostly does not need higher academic qualifications before you become a head but what is very important is the work experience and basic qualification, mostly a diploma. However, per the ministry of health requirement, apart from the work experience, you need a minimum of a master's degree to be a principal (MoH, 2015).

As seen in chapter 4, a rural health tutor who has a nursing background (Rural nurse, R15) said; there are many tutors in the urban areas, and because of that, they are not respected as expressed by one of the tutors in the urban area. This is because there is an overconcentration of tutors in the cities. This is in line with other studies which says that highly trained health workers tend to be concentrated in urban and wealthier areas – possibly reflecting the higher cost of education and hence a more substantial need to achieve a higher income level. In contrast, in the rural and more deprived areas, the percentage of workers with less (or no formal) training tends to be higher (Lemiere et al., 2011). In Ghana, 69 percent of all doctors practice in the Greater Accra or Kumasi, the two most significant urban centres in the country (Snow et al., 2011). In Bangladesh, 35 percent of the doctors and 30 percent of the nurses practicing in the public sector are in metropolitan areas, containing only 15 percent of the country's population (Dussault and Franceschini, 2006). In Sudan, the doctor to population ratio in urban settings is 24 times higher than in rural locations. The same indicator for nurses is 20 times higher in urban places (Lemiere et al., 2011). Among the middle-Income countries, South Africa, where 46 percent of the population lives in rural areas, only 12 percent of the doctors and 19 percent of the Nurses practice there (WHO, 2010). Approximately 43 percent of Brazilians live in the Southeast Region and are served by 58 percent of the total number of doctors in the country.

On the other hand, the North and Northeast regions, the poorest regions in the country, represent 7.7 percent and 28 percent of the total population. Still, they are served respectively by only 4 percent and 16 percent of the total number of doctors in the country (Povoas and Andrade, 2006). The spatial maldistribution of the health workforce presents a severe obstacle to the achievement of crucial national development goals such as the new MoH policy reform of siting new schools outside the capital and attaining universal health coverage. It raises equity concerns since it affects the access of health care for those with the highest relative needs, and allocative efficiency concerns as resources are not distributed towards areas where they would have the most significant impact. Additionally, excessive concentration of health care professionals in urban areas might also be contributing to overutilization or inappropriate uses of services, such as over-prescription of drugs or laboratory tests, leading to wastage of scarce resources (Serneels et al., 2010; Chen, 2010).

From survey question E9 (As a tutor in the MoH, where will you like to move to teach when given the opportunity? (For both rural and urban teachers)). It was found that health tutors leaving the training institutions in Ghana are 1:4 more likely to move from rural areas to urban areas. Reasons given for asking to move to the urban area vary by socio-demographic status. From survey question E3 (why would you like to teach in the urban area), some health tutors (72%) believe that there are more opportunities in promotions and a better work environment than the rural area. Besides, health tutors also said there were more interested in the need for excellent social amenities, good schools for children, and academic progression. This finding is similar to studies conducted by Blauw *et al.* (2010); Rourke (2010); Dolea *et al.* (2010), and Lehmann et al. (2008), which noted that most health workers unwillingness to accept posting to rural areas is because of the lack of motivational factors such as social amenities; professional life, and opportunity for further education/career advancement. These findings are supported by a qualitative study in Ghana among 49 trainee midwives (Lori et al., 2012).

This found that most respondents indicated their unwillingness to accept posting to rural areas because of a lack of better working conditions. This is similar to a study conducted in Uganda among trainee health professionals, which found that most of them were not willing to work in the rural area because of poor unfavourable working conditions (Rockers et al., 2012).

From survey question E2 (why would you like to teach in the rural area), another essential finding indicated that some staff (18%) prefers to go to the rural area because of the low cost of living while others gave different reasons. Most health tutors in the urban area complained of the severe living conditions in the urban area, especially rent, food, and transport. Many health tutors said that low salaries and a large dependency ratio forced them to move from urban areas to rural areas. In the cities, the cost of living is very high, especially for newcomers who do not earn a lot but are expected to rent a house, pay for utilities, transportation, and food. Therefore, as family sizes increase, tutors prefer to move away from the high cost of living in urban areas to a rural area where the cost of living is moderate. This relocation is more economical to enable them to save money and take better care of their families.

Finally, in terms of retention, health tutors in the urban area who are not well motivated were 1.09 times more likely to move to the rural area, as seen in chapter 6. This could be because when people are content with their current conditions, they do not have the desire to change their place of work. However, when they are not motivated, they tend to look for other sites to be motivated to stay and work. This finding concurs that the willingness of employees to work and stay in an organization depends on the extent to which they are adequately motivated (Adams and Hicks, 2000).

7.8 Connection between motivation and retention

Employee motivation is one of the critical factors that can help the employer improve employee and organizational performance. Various theories of motivation have been examined in the

literature. The researcher has confidence that employee retention can be practiced better by motivating the employees. Retention is not only essential to reduce the turnover costs, cost of recruitment, and training, but they need to retain talented employees in the organization to avoid possible poaching-

The literature explored both Frederick Herzberg's and Maslow's theories. It was observed that the Maslows theory had some components of the Herzberg two-factor theory of motivation. Maslow believed that there are certain factors that a business should introduce that would directly motivate employees to work harder and which are also called the Motivators. However, certain factors de-motivate employees to work hard, and these are called hygiene factors. Hygiene factors are the most critical Motivators. They are more concerned with the actual job itself. Hygiene factors are factors which 'surround the job' rather than the job itself. Herzberg argued that employees are motivated by internal values rather than values that are external to the work. In other words, motivation is internally produced and is push by variables that are intrinsic to the work, which Herzberg called "motivators". These intrinsic variables include achievement, recognition, the work itself, responsibility, advancement, and growth. Conversely, certain factors cause dissatisfying experiences to employees; these factors mostly result from non-job-related variables (extrinsic). These variables were referred to by Herzberg as "hygiene" factors which, although it does not motivate employees; nevertheless, they must be present in the workplace to make employees happy.

The dissatisfiers are organization policies, salary, co-worker relationships, and supervisory styles (Bassett-Jones and Lloyd, 2005). Herzberg (1959), as cited in Samuel M. and Chipunza C. (2009), argued further that eliminating the causes of dissatisfaction (through hygiene factors) would not result in a state of satisfaction; instead, it would result in a neutral state. Motivation would only happen as a consequence of the use of intrinsic factors. Empirical studies (Kinnear and Sutherland, 2001; Meudell and Rodham, 1998; Maertz and Griffeth,

2004) have, however, indicated that extrinsic factors such as competitive salary, good interpersonal relationships, friendly working environment, and job security were key motivational variables that influenced their retention in the organizations. The implication of this, therefore, is that management should not depend only on intrinsic variables to affect employee retention; instead, a combination of both intrinsic and extrinsic variables should be considered as an effective retention strategy (Tizazu, 2015).

CHAPTER 8

CONCLUSION AND RECOMMENDATIONS

8.1 Introduction

This chapter contains three sections that will provide a summary of the research findings. The first section will give a summary of the study and the major findings of the study. The second section is a summary of the conclusions derived from the research. The third section deals with the recommendation for this study based on the research findings. The next section deals with suggestions for future studies and, finally, dissemination of Results.

8.2 Summary and Major Findings

The issue that forms the basis for this research is based on the large class sizes, heavy workload based on massive amounts of time spent teaching, researching, marking large numbers of scripts, imbalance in the work-life of health tutors in public health training institutions, particularly in rural areas of Ghana. Annually, an estimated 30% of health tutors in Ghana's rural areas request transfer to urban health training institutions (Ministry of Health, 2013). The migration of tutors from rural to urban within the ministry of health and from the ministry of health to the ministry of education adversely affects the standard staffing norm target of 1:5 set by the ministry of health for the health training institutions. It is estimated that the tutor to student ratio in a typical rural health training institution is 1:30 compared to that of the urban, which is 1:10 (Ministry of Health, 2013). These transfers end up creating a disproportionate tutor to student ratio between rural and urban health training institutions and potentially affecting the performance of health training institutions in the country.

The work-life imbalance has resulted in some health tutors, particularly in the rural areas leaving greener pastures elsewhere. This problem, which is not limited to Ghana, has attracted the attention of the World Health Organization. In response, the World Health Organization proposed, among other strategies, attraction and retention policies, a manageable workload, continuing education, and professional development, family and lifestyle incentives, hardship allowances, housing and education allowances, adequate facilities and working tools, and equitable deployment of health workers to rural and underserved areas (WHO, 2016). This mixed methods study examined how tutors of public health training institutions were motivated and retained at their posts in rural or urban areas of Ghana. An exploratory sequential design was used first to explore qualitatively to develop a context-specific and sensitive quantitative survey instrument to be administered to a large sample of tutors in public health institutions in Ghana. The first phase of the study was qualitative research on how tutors of public health training institutions are motivated and retained in a rural and urban area in Ghana. Interview data were collected from tutors at a rural and urban public health training institution. From this initial exploration, the qualitative findings were used to develop assessment measures administered to a large sample. In the quantitative phase, survey instrument data was collected from the tutors of public health institutions in a rural and urban area of Ghana to examine how the tutors were adequately motivated and retained.

The study was supported by relevant literature regarding worker motivation, retention, and equity at the workplace. The topical literature reviewed included motivation, the types of motivation, intrinsic and extrinsic motivation, factors that affect motivation, job design and working environment, performance management systems, training and development of workers, retention, retention management, retention factors for employees, learning and working climate, job flexibility, superior-subordinate relationship, employee motivation, equity, and promoting equity at the workplace. Additionally, the study used the Two-factor

Theory of Herzberg and Equity Theory as theoretical frameworks to guide the study. Herzberg's two-factor theory, also known as Herzberg's motivation-hygiene theory, was the theoretical lens to study the issue of health tutor motivation and retention. The theory postulates that when particular human needs are referred to as motivators (recognition, work itself, achievement, advancement, and responsibility) are met, satisfaction is increased. On the other hand, when factors referred to as *hygiene* (supervision, salary, working conditions, interpersonal relations, policy and administration, and personal life) are not gratified, negative attitudes are created, leading to job dissatisfaction. However, the satisfaction of *hygiene* factors leads to only minimal job satisfaction (Herzberg, 1959). Herzberg (1982) asserted that factors that promote positive job attitudes (motivators) do so because of their potential to satisfy psychological growth.

Equity theory, developed by John Stacy Adams, also known as the equity theory of motivation, was the second theoretical framework used to guide the study. The theory states that workers are motivated by perceptions of fairness of working conditions in the workplace. Workers use social comparison to adjust to their work when they are unfairly treated (Al-Zawahreh, & Al-Madi, 2012; Adams, 1963, 1965; Nohria et al., 2008). Perceptions of inequity interfere with worker motivation, and to reduce such perceptions of injustice, workers adopt one of three ways: try to increase their outcomes by seeking increased benefits such as a pay increase or other reward; try to quit the job and find another job; or reduce inputs by expending fewer efforts on the job (Baron, 1998).

The significant findings of the research question on motivation and retention and the research question on equity were obtained purposively through focus group discussions, interviews of health tutors and principals, and case studies. The focus group discussions and interviews were recorded on audio, transcribed by the researcher, and analysed to determine thematic patterns. These themes were then used to guide the formulation of the quantitative survey questionnaires.

The findings of the research question on health tutor motivation and retention revealed that health tutors in rural areas were primarily motivated to remain at their locations by money and verbal encouragement and moral support. Health tutors in urban areas are also motivated to stay at their locations mainly by money and provision of accommodation.

Findings of the research question on motivation by equity at health training institutions in the rural and urban areas revealed that health tutors in rural areas were motivated to leave due to unfair workload and benefits compared to colleagues in urban areas. To be motivated to continue staying at the rural health training institution, there was the need to be promoted to balance the inequitable working conditions. Other findings among rural health tutors included considering that unfair treatment was better than the poverty background that they came from and therefore made them grateful instead of agitating for more. Another finding was that it was okay to work long hours without the requisite incentive because they believed their reward was in the next life. The results of the urban areas included mobilizing and striking against the health training institution administration for the unfair remuneration for work, adopting the strategy of reducing work inputs such as withholding grading of examination scripts and not attending classes. Also found was the belief among some health tutors that unfair compensation of work was a blessing, and the reward will be reaped in the afterlife.

The quantitative research findings confirmed the questions of the first and second research questions. It was, however, found that very young and middle age tutors define motivation to be money. In their appraisal, they ranked money as the most significant thing to motivate them. While the elderly group nearing retirement age (50-60) defines accommodation as motivation and the most considerable something to motivate them. The findings of the third research question confirmed the results of the second research question that health tutors compare themselves to their urban counterparts. Secondly, rural health tutors were also of the view that they were inequitably treated compared to those in the urban areas. The health tutors in the

rural areas felt the workload of tutors in the urban areas was lesser than their workload, and the incentive packages that accompanied the light workload of urban health tutors were higher than those of rural health tutors.

8.3 Conclusions

The data collected in this study support several conclusions. The first conclusion is that money is the primary driver of motivation among health tutors, both in rural and urban areas. This finding aligns with the factors identified by Herzberg's motivation-hygiene theory as a hygiene factor, which, when not satisfied, leads to worker dissatisfaction. The hygiene factors identified by Herzberg include company policies, supervision, relationships, work conditions, remuneration, salary, and security (Herzberg, 1959). This finding aligns this researcher's assertions that motivation needed to be contextualized with the cultural settings of research participants because money is not one of the motivators identified by Herzberg (1959). However, money in the form of remuneration and salary is defined as part of the hygiene factors which, when not met, makes workers dissatisfied with the work.

The second conclusion from the data is that while health tutors in rural areas were more interested in the encouragement and moral support they receive for their performance, those in the urban areas were interested in accommodation. The peculiar needs may explain the different factors of motivation between health tutors in the rural and urban areas within the two environments. The choice of urban health tutors of accommodation as a motivating factor is because accommodation is an essential need in urban areas of Ghana. There is a shortage of affordable housing facilities for workers in urban areas of Ghana, and this is compounded by rural-urban migration. On the other hand, rural health tutors stated encouragement and moral support as a motivator because they live in a region that lacks basic amenities. To psychologically deal with the lack of necessary facilities in the rural area, the health tutors

needed to be verbally persuaded and encouraged to continue to live and work in the rural area. The findings of accommodation and worker encouragement belong to hygiene factors of Herzberg motivation-hygiene theory when not satisfied leads to worker dissatisfaction. Housing is a security issue, and motivation and moral support is a supervision and relationship issue (Herzberg, 1959).

The third conclusion from the data is that health tutors in the rural and urban areas experience perceived inequity. Health tutors in rural areas compare their inputs and outcomes with those in urban areas. They feel that they are unequally treated, given their heavy workload and corresponding remuneration and salaries. As a solution to the inequitable treatment, they advocate for the promotion and or increase compensation to balance their inputs and the outcomes they receive. Since feelings of inequity interfere with work motivation, rural health tutors use two of the three strategies used by workers when faced with perceived injustice at the workplace. The rural health tutors seek increased outcomes-increased remuneration and promotion or decide to quit the job in the rural area and move to the urban area as a solution (Hoy & Miskel, 2013). Regarding the urban health tutors, their approach to perceived inequity is to balance inequity by reducing their input, such as not attending classes, not marking examination scripts of students, mobilizing themselves, and agitate for increased remuneration. The actions of urban health tutors also align with two of the three strategies workers use when inequity interferes with work motivation (Hoy & Miskel, 2013).

The fourth conclusion is that the quantitative study supports the qualitative exploratory study that unmet work-related needs of health tutors are linked to their retention, especially in rural areas. That money in the form of increased remuneration and salaries is the main hygiene factor that creates job dissatisfaction. The other hygiene factors include providing accommodation and verbal persuasion in the form of encouragement and moral support from supervisors and principals. Additionally, there is a perception among rural health tutors that their managers

better treat their urban counterparts of the health training institutions. A large proportion (63%) of the health tutors in the Ministry of Health feel that their input is not reflective of the outcomes or benefits they receive. About three-quarters of health tutors (73%) believed that there is an inequity between their inputs and outcome ratios compared to others. This perceived inequity in rural areas, especially, is the main reason why health tutors resign their jobs to move to urban areas.

8.4 Recommendations

From the studies, it was observed that there are some differences between the health tutor and general health worker. It is, therefore, necessary that recommendations are made based on this research to address the critical factors of motivation and retention amongst health tutors in public health training institutions in Ghana. These include:

1. From this research, money consistently featured as a major factor in addressing tutor motivation and retention, and therefore providing additional money for those located in the rural areas and those with higher workloads could be an excellent factor to motivate them to work and retain them at the post. The Ministry of Health in Ghana is kindly advised to introduce rural allowances for health tutors who work in rural areas. There is also the need to introduce book and research allowance for tutors both in the rural and urban areas.
2. From the focus group discussion, health tutors close to their retirement tend to think much of a house to lay their heads after retirement while others had different views. Therefore, diversification of good retirement packages for years of services provided by soon to be retired and dedicated health tutors. Health tutors need to be rewarded based on their longevity of service and commitment. Others might have worked for only 12 years and going on retirement while others worked for 32 years before going on retirement. It will be appropriate that the ministry of health considers the number of years of service and

commitment to providing varied options of retirement packages for those going on retirement. The package should not be the same. As seen in this research, options should be varied. Others might want a house to acknowledge their many years of dedicated services while others may require a car, and so on. Therefore, the retirement package should be varied based on need and years of services.

3. Make available adequate and affordable accommodations for all health tutors close to campus. Where accommodations cannot be fully provided, it is recommended that the ministry of health make partial financial support for health tutors to pay for their accommodation. However, either it should be mandatory to provide accommodation or stipend be provided for accommodations to health tutors in the rural area. Health tutors with staff quarters need to be supported to maintain it. Staff quarters that are occupied by health tutors need to be renovated periodically by the ministry of health to ensure that the health and safety of the staff are not compromised.
4. From the research findings, it was observed that the entitled group of tutors felt they should've been provided with fuel allowances; however, the schools were unable to pay due to lack of funds. The ministry of health must ensure that contractual agreements are honored, and when they cannot be honored, they should communicate to staff and be renegotiated to suit the current financial challenges being faced by the employer. This is very necessary for terms of the conditions of services for health tutors. The Ministry needs to ensure that it fulfills its part of the obligation to promise health tutors. If contractual and conditions of services are not met, this could lead to dissatisfaction, low productivity, and high turnover.
5. The Ministry of Health needs to introduce non-monetary incentives, such as identifying and broadcasting the best employee of the region or area. Giving one day off to hard-working, committed staff, and holding staff dinners to thank and show appreciation to staff for their

hard work and commitment to service. A surprise gift of appreciation for staff in the form of books, a party, or a letter could also make staff feel well appreciated.

6. The health training institutions will have to provide monthly and annual training to ensure all health tutors are updated on current practices and changes occurring in the health field. These monthly training should be continuous professional development to be counted as part of their promotion requirement. This form of monthly seminar/workshop or training needs to be made mandatory for all schools in the ministry of health. It will give all tutors, irrespective of location, fair opportunity for training and professional development and will avoid the situation of health tutors seeking to work in the urban area because of opportunity for further training and also the perception of out of sight, out of mind (if you are not closer to Accra, you are forgotten in the rural area).

8.5 Suggestions for Future Research

Upon completion of the data collection and reflection, this researcher recognized several potential areas in which future researchers may choose to extend the findings of this study. The focus of this study was first to use the explanation given to assess their motivation and retention. Secondly, the study attempted to compare the motivation and retention of select health tutors of rural north to their counterparts in the urban south. Thirdly, only health tutors in the public sector whose institutions are supervised by the Ministry of Health were included in this study.

In the future, potential researchers could concentrate on conducting a quantitative study that includes all health tutors in Ghana, including those who work for for-profit and non-profit organizations. The study should be entirely based on the Herzberg motivation-hygiene factors of motivation. The motivators and well hygiene factors, as spelt out by Herzberg (1959), should be tested within the Ghanaian context for its reliability.

Secondly, future studies should examine specific factors that cause health tutors to decide not to work in the health sector anymore. This broader study would provide the Ministry of Health with invaluable information on health tutor attrition and retention rates. Large sums of money are invested in training health tutors, and for them to leave the sector after working for only short periods requires more in-depth investigation and analysis.

Thirdly, further studies should be conducted in the role of equity in health tutor motivation and retention. The research should focus specifically on the strategies used by health tutors to remedy and balance perceived inequity in their institutions. A study of this nature would help umbrella organizations overseeing health training institutions set up effective systems of handling equity issues. The issue of equity is important because it is not only an issue of perception of inequity. The issue of equity is also an ethical and human rights issue.

This study used exploratory sequential mixed methods study as the methodological design where the qualitative research on motivation, retention, and equity was first examined, and the results were used to design the quantitative research. Focus group discussions, interviews, and case study methods were used to collect the exploratory qualitative data. In the future, the methodological design could be reversed using explanatory sequential mixed methods study where the quantitative research would be conducted first using the constructs of Herzberg's two-factor theory and Equity theory. After that, the results of the quantitative data would be used to design a qualitative study to explain the statistical findings.

8.6 Dissemination of Results

The results of this study would be disseminated continuously through active engagement with stakeholders such as the Ministry of Health, the Health Training Institutions, and District

Health Management Teams. They have direct oversight responsibility of clinical sites where tutors and their students go for clinical work.

Research-to-policy briefs would be produced in the form of flyers distributed to officials of the Ministry of Health and the Ghana Health Service during health policy review meetings and senior managers meetings. With the approval of the leaders of the Ministry of Health and Ghana Health Services, the policy briefs would be posted on official websites of these organizations for their members to assess.

The final thesis of this research study will be disseminated through workshops conducted in all the participating institutions and at the regional clinical review meetings where heads of all health training institutions will be represented. Moreover, scientific papers from this study will be public in peer-reviewed journals as part of the dissemination strategy.

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APPENDICES

Appendix 1: MoH ethical clearance

**In case of reply the number
And the date of this
The letter should be quoted**



**MINISTRY OF HEALTH,
P O Box M – 44,
Accra.**

**My Ref. No.
MOH/HRHD/GEN/33**

17th December 2015

Your Ref. NO.

REPUBLIC OF GHANA

AS PER DISTRIBUTION

ETHICAL CLEARANCE FOR RESEARCH WORK

The Ministry of Health has granted approval to Mr Christopher Beyere to conduct research in selected health training institutions in the northern and southern parts of the country on the topic “Health tutor motivation and retention in Ghana”

This is part of his Ph.D. research work which will be useful to the ministry of health.

DR. ROBERT KABA

The ethics committee, HTI

Distribution

- 1. CHIEF DIRECTOR, MOH**
- 2. D-G, GHANA HEALTH SERVICE**
- 3. DIRECTOR, HRHD**
- 4. THE REGISTRAR, NMC**
- 5. THE CHIEF NURSING OFFICER, GHS**
- 6. THE PRESIDENT, COHHETI**

Appendix 2: Focus group discussion protocol (FOR HEALTH TUTORS ONLY)

Topic: Understanding health tutors motivation and retention

Materials to bring:

- a. Notebook/computer or tape recorder to record proceedings
- b. Flip chart paper if no board is available
- c. Focus group list of participants
- d. Focus group script
- e. Name tags
- f. Watch or clock

Ground rules

- Arrive before the participants to set up the room, refreshments, etc.
- Introduce yourself and the note-taker (if applicable) and carry on the focus group according to the script.

Conduct the session, being mindful of the following:

- a. Set a positive tone.
- b. Make sure everyone is heard; draw out quieter group members.
- c. Probe for more complete answers.
- d. Monitor your questions and the time closely – it is your job to make sure you are on track.
- e. Don't argue a point with a participant, even if you consider that they are wrong.
Address it later if you must.
- f. Thank participants and tell them what your next steps are with the information.

Introduction:

This qualitative questionnaire is designed to gather baseline information on factors that influence health tutor motivation and retention and its effects on the performance of health training institutions in Ghana.

You are hereby informed that throughout the interview session, your voice will be tape-recorded for subsequent transcription and analysis. The information will be used for academic purposes only.

You are also reminded that participation in the personal interview is voluntary and anonymity and confidentiality of personal information are assured. None of your responses here will be directly linked to you in person. You could also decide to withdraw from the interview anytime you so wish to without any consequences. Do you consent to voluntarily participate in this interview?

IF YES Please sign.....OR

Thumbprint.....

Contact of Researcher: Tel/ E-mail:

NO of participants:

Today's date:

No Males:

No of Females:

Section A: Background information and motivation for tutorship

1. Brief introduction of yourself
 - a. Probe name, education from primary to tertiary, family background
 - b. What motivated you into tutorship
 - c. What are your future plans?
2. What is your present job title?
3. What do you do at your present job?
4. How long have you been at your present job?yearsmonths

5. How were you posted here?

Probe: Own request or by the ministry of health

B: Interviewee perspectives on workplace motivation factors

4. Please describe what you think constitutes motivation?

Probe:

Examples

5. Would you describe yourself or colleagues in this institution as well-motivated?

Probe:

- How
- Why

6. What factors do you think hinder or promote the motivation of staff in this institution?

Probe:

- Why

C: Interviewee perspectives on workplace retention factors

1. Please describe what you think constitutes staff retention?

Probe:

1. How many years have you worked here?
2. Do you like it over here?
3. Why do you like it here?
4. How many more years will you like to stay here?
5. What are the factors that could move you out of this place?
6. What are the factors that could keep you here for a longer period of time?
7. what is the longest number of years the staff has served here?
8. What is the shortest time the staff has served here?
9. When was the last time you received new staff posted to your school?

10. When was the last time the staff left the school?

11. How many staff leave the school per year (average)?

12. Would you describe yourself or colleagues in this institution as people who are ready to stay for at least the next year?

Probe:

- How
- Why

14 . What factors do you think hinder or promote retention of staff in this institution?

Probe:

- Why

15. What factors do you think hinder or promote motivation of staff in this institution

a. Probe:

16. What is the key thing that will motivate you to work in a rural area?

17. What are the key things that will demotivate you when working in a rural area?

18. What are the key things that will motivate you to work in an urban area?

19. What re the key things that will demotivate you in the urban area?

Section D: Equity

D1: Do you compare yourself to others?

D2: whom do you compare yourself to?

D3: What do you sometimes compare with the others?

Probe further in areas of:

Salary

Hours of work

Qualification

Allowances

D4: Why do you compare? Why don't you compare?

D5: Do you think other colleagues compare themselves to you?

D6: when you compare to others do you think you are being treated fairly?

D7: Which areas are you treated fairly?

Probe further in terms of:

Salary

Promotion

Posting

Career devt/training

Accommodation

Allowances/bonus

D8: Which areas are you not treated fairly

Probe further in terms of:

Salary

Promotion

Posting

Career devt/training

Accommodation

Allowances/bonuss

D9: Do you demand equity

Probe further. How the demand equity

*by force or subtle way

D10: How do they react in situations of inequity?

Probe further

Thank you

Appendix 3: In-depth interview protocol (FOR PAST HEALTH TUTORS ONLY)

Topic: Understanding health tutors' motivation and retention and its effects on the performance of health training institutions in Ghana. (60 minutes total)

Name of Interviewer:.....

Designation of interviewee.....

School:.....

Date and time of interview.....

Testing materials

- Audio recording equipment.
- Speakerphone.
- A consent form and.
- Interviewer clock.

Procedures for obtaining informed consent

FOR TELEPHONE: Participants will be sent an informed consent form before the interview.

At the start of the interview, the interviewer will ask if the participant has any questions about the consent form and if he or she agrees to be interviewed and audiotaped then the interview will then commence.

Preamble

This qualitative questionnaire is designed to gather baseline information on factors that influence health tutor motivation and retention and its effects on the performance of health training institutions in Ghana.

You are hereby informed that throughout the interview session, your voice will be tape-recorded for subsequent transcription and analysis. The information will be used for academic purposes only.

You are also reminded that participation in the personal interview is voluntary and anonymity and confidentiality of personal information are assured. None of your responses here will be directly linked to you in person. You could also decide to withdraw from the interview anytime you so wish to without any consequences. Do you consent to voluntarily participate in this interview?

IF YES Please sign.....

OR

Thumbprint.....

Contact of Researcher: Tel/ E-mail:

Section A: Background information of interviewee

1. Age.....
2. Gender.....
3. Highest education attained.....
4. Years of work experiences.....
5. Specialty area.....
6. Region.....
7. District.....
8. Institution.....
9. Institution ownership.....
10. Could you please describe your responsibilities in your current position?
11. Please describe how you report to work on a typical day?

Probe:

- Means of travel
- Time of travel
- Distance

12. Could you please describe your typical duty day in this institution?

Probe:

- Time of arrival at work
- Communication/interaction with students
- Challenges
- Motivations
- Time of closure

Reasons for leaving health training institution

1. Why did you leave your former institution for this new place?
2. What is your new institution doing that your former institution is not doing?
3. What would you like to see in your former institution that will make you happy to go back and work there?
4. What attracted you to this new institution?
5. Were you motivated in your former institution and why?
6. Are you motivated in your current institution and why?
7. What could have been done to retain you in the former institution?
8. Do staff compare themselves to their colleagues in other schools?

Probe further: what do they compare with

What are their reasons for comparing?

9. Do staff believe inequity? Do they demand equity in terms of what?

10. How do they react in situations of inequity? Probe further
11. What is the most important message that you want us to take away from this interview?
12. Is there anything else that you would like to add about any of the topics that we've discussed or other areas that we didn't discuss but you think are important?

Thank you for your time and participation in this interview. The information that you provided to us will be very helpful in this project.

THANK YOU VERY MUCH FOR YOUR TIME.

<i>END</i>	<i>Hr.</i>	<i>Min.</i>	<i>Sec.</i>
<i>TIME</i>			

Appendix 4: Key Informant Interview Protocol (FOR PRINCIPALS ONLY)

Topic: Understanding health tutors' motivation and retention and its effects on the performance of health training institutions in Ghana. (60 minutes total)

Name of Interviewer:.....

Designation of interviewee.....

School:.....

Date and time of interview.....

Testing materials

- Audio recording equipment.
- Speakerphone.
- A consent form and.
- Interviewer clock.

Procedures for obtaining informed consent

FOR TELEPHONE: Participants will be sent an informed consent form before the interview.

At the start of the interview, the interviewer will ask if a participant has any questions about the consent form and if he or she agrees to be interviewed and audiotaped then the interview will then commence.

Preamble

This qualitative questionnaire is designed to gather baseline information on factors that influence health tutor motivation and retention and its effects on the performance of health training institutions in Ghana.

You are hereby informed that throughout the interview session, your voice will be tape-recorded for subsequent transcription and analysis. The information will be used for academic purposes only.

You are also reminded that participation in the personal interview is voluntary and anonymity and confidentiality of personal information are assured. None of your responses here will be directly linked to you in person. You could also decide to withdraw from the interview at any time without consequences. Do you consent to voluntarily participate in this interview?

IF YES Please sign.....

OR

Thumbprint.....

Contact of Researcher: Tel/ E-mail:

Section A: Background information of interviewee

1. Age.....
2. Gender.....
3. Highest education attained.....
4. Years of work experiences.....
5. Specialty area.....
6. Region.....
7. District.....
8. Institution.....
9. Institution ownership.....
10. Could you please describe your responsibilities in your current position?
11. Could you please describe your typical duty day in this institution?

Probe:

- Time of arrival at work

- Communication/interaction with students
- Challenges
- Motivations
- Time of closure

12. How many institutions have you worked for?

13. How many are in the north?

14. How many are in the south?

15. From your experience what is the difference between the two

Section c

1. In your view what is motivation based on your location?
2. Why do you think some health tutors leave their former institution for new institutions?
3. What are some of the institutions doing that your health training institution is not doing?
4. What would you like to see the health training institution doing that can motive staff and retain staff?
5. What attracted you to this new institution?
6. Were you motivated in your former institution and why?
7. Are you motivated in your current institution and why?
8. What could have been done to retain more staff?

Section D: Equity

1. Do staff compare themselves to their colleagues in other schools? Probe further: what do they compare with and for what?
2. Do staff believe inequity? What do they demand equity in terms of what (salary, allowance, pay, work-life balance)
3. How do they react in situations of inequity? Probe further

****By force demand for equity, gently and subtle way or no demand at all**

4. What is the most important message that you want us to take away from this interview?

5. Is there anything else that you would like to add about any of the topics that we've discussed or other areas that we didn't discuss but you think are important?
-

Closing

.Thank you for your time and participation in this interview. The information that you provided to us will be very helpful in this project.

THANK YOU VERY MUCH FOR YOUR TIME.

<i>END</i>	<i>Hr.</i>	<i>Min.</i>	<i>Sec.</i>
<i>TIME</i>			

Appendix 5: Survey form

CROSS-SECTIONAL SURVEY GHANA											
SECTION A: IDENTIFICATION SHEET											
		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px;"></td> <td style="width: 30px; text-align: center;">Hr.</td> <td style="width: 30px; text-align: center;">Min.</td> <td style="width: 30px; text-align: center;">Sec.</td> </tr> <tr> <td style="text-align: center; vertical-align: middle;">Start time</td> <td></td> <td></td> <td></td> </tr> </table>			Hr.	Min.	Sec.	Start time			
	Hr.	Min.	Sec.								
Start time											
1. REGION..... 	2. DISTRICT..... 	3. DISTRICT/CODE..... 									
4. NAME OF INST..... ...	5. INST. CODE.....	6. INST. OWNERSHIP (PRIVATE/PUBLIC)									
7. INST. STAFF CODE.....	8. NAME OF INST. STAFF	9. DESIGNATION OF STAFF									
10. CONTACT OF STAFF (TEL. NO./e-mail): 											
Date (dd/mm/yy)	i) First visit /...../	ii) Second visit: /...../.....	iii) Third visit: /...../..... 								
11. Name of Interviewer:											
Result:											
Result codes: (1) Staff Interviewed (2) INST. not found; (3) Staff Absent (4); Refused (5) Other (specify)											

Remarks:.....

SECTION B: STAFF INFORMATION

INSTITUTION CODE:

QUESTIONS	RESPONSE	CODE
I would like to ask questions about you and your work in this institution		
B1: Gender of the interviewee (Interviewer does not have to read out: Observe)	Male.....1 Female.....2	<input type="text"/>
B2: What is your age (in years)?	Please specify ____ ____	
B3: What is your marital status?	Never married.....1 Married.....2 Divorced.....3 Separated.....4 Widow (er).....5 Living together.....6	<input type="text"/>
B4: What is your religion?	Christian.....1 Muslim2 Traditional.....3 None4 Other (please specify)	<input type="text"/>
B5: What is your current educational qualification?	O'Level or JSS certificate.....1 A'Level or SSS certificate.....2 Diploma.....3 First Degree.....4 Second Degree.....5 Other (please specify)	<input type="text"/>
B6: How many people are living with you as dependants in your house?	Number ____ ____ (If the answer is zero (0), skip B7 and B8)	

SECTION F: EQUITY AT THE WORKPLACE

STATEMENT		RESPONSE	CODE
F1: Do you compare yourself to others?		Yes ____ ____ No No idea.....98	<input type="text"/>
F2: whom do you compare yourself to?	B7: Are you financially taking care of any person living with you in your household?	In the same school No.....2 Outside the school No idea.....98 (Skip B8 if 2)	<input type="text"/>
F3: What do you sometimes compare with the others?	B8: How many of these people living with you are you financially taking care of?	Salary Hours of work Qualification Number ____ ____ allowances ____ ____ No idea.....98	<input type="text"/>
F4: Why do you compare?		For fairness	
F5: Do you think other colleagues compare themselves to you?	B9: What is your professional category?	Don't compare No idea.....98 Please specify [Number of minutes].....	<input type="text"/>
F6: when you compare to others do you think you are being treated fairly?	B10: What is your regular mode of transport to work on a daily basis?	Walk.....1 No idea.....98 Bicycle.....2 Yes Motor cycle.....3 No ____ ____ Public transport.....4 No idea.....98 Personal car.....5	<input type="text"/>
F7: which areas are you treated fairly?	B11: Averagely how many minutes does it take you to travel to work on a daily basis?	Salary Other (please specify)..... Promotion Please specify [Number of minutes]..... Extra hours Career devpt/training Accommodation____ Allowances/bonu	<input type="text"/>
F8: which areas are you not treated fairly?	B12: Do you sometimes report to work late?	Yes.....1 No idea.....98	<input type="text"/>
F9: when you are not treated fairly how do you react	B13: In a week how many times do you report to work late?	Salary No.....2 Promotion Extra hours (Skip B14 if 2) Career devpt/training Once.....1 Accommodation____ Twice.....2 Allowances/bonu Three times.....3 No idea.....98 Four times.....4 Five times.....5 1. No problem 2. Feel very bad but feel good when issues are explained to me Throughout the week.....6	<input type="text"/>
		3. Fair treatment is my right 4. No idea.....98	
F10 What are you not treated fairly in?		Salary Promotion1	<input type="text"/>

B14: How many hours do you spend on an average day working in this institution?	Please specify [Number of hours].....	
B15: How many hours are you supposed to work in this institution in a day?	Please specify [Number of hours].....	
B16: Are you ok working extra hours than others?	Yes.....1 No.....2	<input type="checkbox"/>
B17: What is the range of your monthly salary in this institution?	Please specify [Amount in GHC].....	
B18: Do you receive any work allowance from this institution outside your monthly salary?	Yes.....1 No.....2 (Skip B19 if 2)	<input type="checkbox"/>
B19: Approximately how much do you receive from this institution in a month as a marking allowance outside your monthly salary?	Please specify [Amount in GHC].....	
B20: Apart from your work in this clinic do you do any additional work?	Yes.....1 No.....2 (Skip B21-B22 if 2)	<input type="checkbox"/>
B21: How many additional works do you do? (Multiple Responses Allowed)	Additional work 1 : Type of work: [specify] Number of hours per week: _____ _____ Additional income from this work in a month: [specify].....	

			Additional work 2 : Type of work: [specify] Number of hours per week: _____ _____ Additional income from this work in a month: [specify].....	
			Additional work 3 : Type of work: [specify] Number of hours per week: _____ _____ Additional income from this work in a month: [specify].....	
		B22: Have you been posted before?	Yes NO	
		B23: How were you posted here?	a. Own request1 b. Ministry posting2	<input type="checkbox"/> <input type="checkbox"/>
		B24: How were you posted to the rural area (*those in rural area only)	a. Own request1 b. Ministry posting2	
		B25: How were you posted to the urban area (*those in urban area only)	a. Own request1 b. Ministry posting2	
		B26: Are you a member of any of these professional associations?	Yes.....1 No.....2 (If 2 skip B26 – B27)	<input type="checkbox"/> <input type="checkbox"/>
		B27: How many of these professional associations are you a member of?	Please Specify [Number].....	
		B28: What is (are) your role(s) in this professional association(s)?	Please specify.....	

B29: How does your membership with this professional association(s) influence your professional practice?	Please specify.....	
SECTION C: TUTORS' EXPERIENCES WITH STUDENTS AND COLLEAGUES IN THE SERVICE DELIVERY PROCESS		
STATEMENT	RESPONSE	CODE
Please indicate your opinion on the following statements regarding the students in your institution		
C1: Out of 10 students how many of them come for lectures late?	Number ____ ____ No idea.....98	<input type="text"/>
C2: Out of 10 students how many of them absent themselves within a week?	Number ____ ____ No idea.....98	<input type="text"/>
C3: Out of 10 students how many of them adhere to instructions you give them including assignments given?	Number ____ ____ No idea.....98	<input type="text"/>
C4: Out of 10 students how many of them exhibit disrespectful character towards you?	Number ____ ____ No idea.....98	<input type="text"/>
C5: Out of 10 patients how many of them commend you for good performance intuition?	Number ____ ____ No idea.....98	<input type="text"/>
C6: Out of 10 patients how many of them complain of the inability to understand your lectures?	Number ____ ____	<input type="text"/>

			No idea.....98		
		C7: Out of 10 patients how many of them default in examinations and class assignments deadlines and schedules?	Number _____ - _____ _____ _____ No idea.....98	<input type="text"/>	

SECTION D: STAFF INCENTIVES AND CAPACITY CHALLENGES AT THEIR WORKPLACE

STATEMENT	RESPONSE	CODE
The interviewer can start with an introduction to this section saying: I would like to ask you some questions about the incentives and constraints that you face in rendering quality tuition to students.		
D1: The physical work environment in the institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>
D2: Monthly salary	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>
D3: Payment of allowances for extra duties (marking allowance)	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>
D4: Possibility for promotion	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>
ED: The reputation and recognition from society due to my job	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>
D6: Attitudes of superiors in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>

	D7: Accommodation facilities for staff in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="checkbox"/>
	D8: Fuel/transportation allowance	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="checkbox"/>
	D9: Opportunity for further education	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="checkbox"/>
	D10: Availability of adequate modern facilities in this institution	Very disappointing 1 2 3 4 Very satisfactory Specify:.....	Not at all 1 2 3 4 Very important <input type="checkbox"/>
	D11: Availability of consumables [health logistics] on a regular basis in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="checkbox"/>
	D12: Number of staff in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="checkbox"/>
	D13: Water supply in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="checkbox"/>
	D14: Electricity supply in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="checkbox"/>
	D15: Responsiveness of students to staff instructions in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="checkbox"/>

	D16: Attitudes of colleague workers in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>
	D17: : Workload in this institution	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>
	D18: Availability of logistics for students and staff on a regular basis	Very disappointing 1 2 3 4 Very satisfactory	Not at all 1 2 3 4 Very important <input type="text"/>
	D19 are you aware of the logistical and financial constraint in the institution?	Yes No If Yes, answer D20	
	D20: If Yes to D19 how do you react to this situation of logistics and financial constraint?	1. No problem 2. Feel very bad but feel good when issues are explained to me 3. Fair treatment is my right 4. No idea.....98	

SECTION E: MOTIVATION

The interviewer can start with an introduction to this section saying: I would like to ask you some questions about equity at the workplace.

Conditions		
E1: In your view what is motivation	a. money b. accommodation c. appreciation d. travel abroad e. encouragement and support	Others, specify:
E2: why would you like to teach in the rural area	b. low-cost living b. recognition n c. accommodation d. no traffic e. inner desire to serve f. Patriotic g. money h. interesting work	Others, specify:
E3: why would you like to teach in the urban area	a. money b. social amenities c. working environment d. promotions	Others, specify:

	e. training & devt. F. schools for kids g. recognition h. interesting wok	
E4: What is the greatest thing to motivate you in the rural area	a. money b. accommodation c. appreciation d. travel abroad e. job involvement f. recognition g. promotion h. training & devt	Others, specify:
E5: What is the greatest thing to motivate you in the urban area	a. money b. accommodation c. appreciation d. travel abroad e. job involvement f. recognition g. promotion h. training & devt	Others, specify:
E6: what do you appreciate most at your present age	a. money b. accommodation c. appreciation d. travel abroad e. job involvement f. promotion	Others, specify:
E7: As a tutor in the rural area, what will force you to leave the MoH job (tutor) completely (rural tutors only)	a. Money b. work conditions c. accommodation d. recognition e. promotion f. Outside MoH experience	Others, specify:
E8: As a tutor in the urban area, what will force you to leave the MoH job (tutor) completely (urban tutors only)	a. Money b. work conditions c. accommodation d. recognition e. promotion f. Outside MoH experience	Others, specify:
E9: As a tutor in the MoH, where will you like to move to teach when given the opportunity? (for both rural and urban teachers)	a. Rural b. Urban c. Any place d. Don't knw Specify:	

E10: How will you rate your overall level of motivation	a. not well motivated at all b. b little bit motivated c. motivated
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